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The purpose of this study was to understand and describe the experience of the intimate dyad after one dyadic member had weight loss surgery (WLS). Obesity is a complex chronic disease with multiple causative factors. Obesity has reached epidemic levels in America with over 60% of adults being overweight or obese (Flegal, Carroll, Ogden, & Curtin, 2010; Ogden & Carroll, 2010). WLS is an option for long-term weight control for those morbidly obese patients for whom other diet and exercise programs have failed (American Society for Metabolic and Bariatric Surgery, 2010b). WLS is becoming more popular as its safety and efficacy are increasing. In 2009, 220,000 patients underwent WLS (American Society for Metabolic and Bariatric Surgery, 2010b; Livingston, 2010).

The literature review revealed a gap in the knowledge regarding the experience of the dyad after WLS. Past research findings were contradictory as to the effects of WLS on the intimate relationship. No studies could be found documenting the experience of the partner of the WLS individual.

A qualitative descriptive design was used. Bodenmann's Theory of Dyadic Coping (2005) was used as a guiding framework for data collection and analysis. Open-ended, semi-structured interviews were conducted with twenty individuals, or ten dyads. Interviews were audiorecorded and transcribed verbatim. Field notes were taken during the interviews and incorporated into the written transcripts. First, data from individual transcripts were analyzed using Colaizzi's (1978) method. Significant statements were

highlighted and placed into broad categories, which were then organized into themes.

Second, a dyadic analysis using the method outlined by Eisikovits and Koren (2010) was performed, examining the transcripts of each dyad, assessing for overlaps and contrasts between their stories. No new themes were found after the dyadic analysis; the story was thoroughly described from the individual data analysis. Findings were presented back to study participants to confirm these findings were an accurate representation of their experience.

Four distinctive themes were developed and validated by the descriptions of the experiences of the participants. The four themes that were developed from the analysis of the formulated meanings were: (1) No longer a slave to food; (2) Good and bad, with subthemes of “the best thing I’ve ever done in my life” and “just let me be normal”; (3) Surgery is just a tool, not the solution; and (4) Support and accommodation. All four themes emerged from the analysis of all participants’ stories. No one theme was dominant, but all themes came from the experience of the dyad after WLS.

Findings from this study have implications for nursing practice and research. If nursing and other disciplines can understand how the dyad reacts and copes to the stress after one member has WLS, education and support can be tailored to providing the best possible outcomes for the dyad: a stronger intimate relationship and long-term weight loss.

THE EXPERIENCE OF THE INTIMATE DYAD AFTER
WEIGHT LOSS SURGERY: A QUALITATIVE
DESCRIPTION

By

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Approved by

Committee Chair

To my family, without whose love, support, and encouragement, this would have never
been possible.

APPROVAL PAGE

This dissertation has been approved by the following committee of the Faculty of
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CHAPTER I

INTRODUCTION

Introduction

Obesity is considered a complex chronic disease with multiple causative factors, including social, economic, cultural, genetic, behavioral, physiologic, psychological, and metabolic components (American Society for Metabolic and Bariatric Surgery, 2010a). Obesity and overweight conditions have reached epidemic levels in America with over 60% of adults reaching overweight or obese standards (Flegal, Carroll, Ogden, & Curtin, 2010; Ogden & Carroll, 2010). The Centers for Disease Control and Prevention (CDC) define overweight as having a body mass index (BMI) $\geq 25 \text{ kg/m}^2$, obese as a BMI $\geq 30 \text{ kg/m}^2$, and extremely obese as a BMI $\geq 40 \text{ kg/m}^2$ (Centers for Disease Control and Prevention, 2010a). The number of American adults who are classified as being obese or extremely obese has steadily increased since 1976; the percentage of obese adults rose from 15% in 1976 to 34.3% in 2008, while the percentages of extremely obese adults rose from 1.4% in 1976 to 6% in 2008 (Ogden & Carroll, 2010). This increase is regardless of gender, education level, or region of the country (American Society for Metabolic and Bariatric Surgery, 2010a). The implications of the rise in obesity levels are staggering.

Obesity has been linked to increases in the incidence of 30 serious medical diseases, increases in mortality from all diseases, impaired mobility, and is now considered by some authorities as the number one preventable cause of morbidity and

mortality (American Society for Metabolic and Bariatric Surgery, 2010a; Centers for Disease Control and Prevention, 2010c; Hicks et al., 2008). Nearly 80% of obese persons have either diabetes, coronary artery disease, hypercholesterolemia, hypertension, gallbladder disease, or osteoarthritis, and 40% of these obese adults have two or more of these conditions (Gabel et al., 2009). Based on recent data, the total medical expenses attributed to obesity range from \$93 billion to \$147 billion annually (Centers for Disease Control and Prevention National Center for Chronic Disease Prevention and Health Promotion, 2010). Obese individuals spend 36% more on health care, an equivalent of \$1400 more per year in 2006 (Centers for Disease Control and Prevention National Center for Chronic Disease Prevention and Health Promotion, 2010), and 77% more on medications than individuals of normal weight (American Society for Metabolic and Bariatric Surgery). Obesity is associated with over 112,000 excess deaths due to cardiovascular disease, over 15,000 excess deaths due to cancer, and over 35,000 excess deaths due to non-cancer, non-cardiovascular disease causes per year in the U.S. population, relative to healthy-weight individuals (Flegal, Graubard, Williamson, & Gail, 2007). Obese persons also suffer emotional consequences, such as stigmatization and discrimination, on a daily basis in their employment and academic settings (Hicks, et al., 2008; Puhl, Moss-Racusin, Schwartz, & Brownell, 2008; Rogge, Greenwald, & Golden, 2004).

Weight loss surgery (WLS), also known as bariatric surgery, provides an option for long-term weight control to those morbidly obese patients for whom other diet and exercise programs have failed (Mitchell & de Zwaan, 2005). Weight loss surgery has

been performed since 1954, although it remained controversial until 1991, when the National Institutes of Health released a consensus statement proclaiming some bariatric surgery procedures safe for some patients (Livingston, 2010). A decade later, there was appreciable growth in the incidence of WLS, and the number of obese individuals undergoing WLS in 2009 reached 220,000 (American Society for Metabolic and Bariatric Surgery, 2010b; Livingston, 2010). Weight loss surgery is indicated for those individuals whose BMI is ≥ 40 or a BMI ≥ 35 in the presence of at least one comorbid condition (American Society for Metabolic and Bariatric Surgery, 2010b; Mitchell & de Zwaan, 2005).

The four most common types of WLS are Roux-en-Y gastric bypass (open or laparoscopic), laparoscopic adjustable gastric banding, biliopancreatic diversion with duodenal switch (BPD), and vertical sleeve gastrectomy (American Society for Metabolic and Bariatric Surgery, 2010b; Mitchell & de Zwaan, 2005). While the gastric banding procedure and the vertical sleeve gastrectomy only allow for a restrictive form of weight loss by decreasing the size of the gastric pouch and therefore limiting the amount of calories consumed, the Roux-en-Y and the BPD are both restrictive and malabsorptive (American Society for Metabolic and Bariatric Surgery, 2010b). Not only is the gastric pouch smaller, but the remainder of the stomach and the duodenum are bypassed; food travels from the small pouch directly to the jejunum, where absorption of nutrients and calories is greatly decreased (American Society for Metabolic and Bariatric Surgery, 2010b).

Studies have shown that persons who undergo WLS can expect to lose 47-80% of excess body weight (Hunt & Gross, 2009; Mitchell & de Zwaan, 2005; Pories, 2008).

Weight loss surgery has been shown to decrease, or even eliminate, many of the comorbid conditions associated with obesity, such as diabetes, sleep apnea, hypercholesterolemia, and hypertension (Pories, 2008; Taylor, 2009). The procedure can decrease the risk of developing coronary artery disease by up to one-half (Taylor, 2009) and reduce the prevalence of cancer by up to 80% within five years postoperatively (Pories, 2008).

Even though the weight loss results and elimination of many comorbidities after surgery are commendable, up to 20% of patients cannot maintain their dramatic weight loss two years after surgery (Meguid, Glade, & Middleton, 2008). The reasons for this weight regain may be physiologic (stretching of the gastric pouch) and/or behavioral/sociocultural (not exercising, not following prescribed food restrictions, expecting the surgery to do all the work) (Wysoker, 2005; Zijlstra, Boeijs, Larsen, van Ramshorst, & Geenen, 2009). In a qualitative study by Zijlstra et al. (2009), participants who failed to lose weight after laparoscopic gastric banding poorly understood how their effort was also needed for the weight loss to occur and had trouble turning awareness of what they needed to do into actually performing the required behaviors. In a study by Elakkary, Elhorr, Aziz, Gazayerli, and Silva (2006), attendance at formal support group meetings gave the WLS individuals a place to go to ask questions about their postoperative regimen and to get feedback from others about their adherence to the program and their weight loss progress. These authors concluded that social support, in

the form of support groups, can increase adherence to the prescribed postoperative requirements and help achieve improved weight loss (Elakkary, et al., 2006).

Several studies show improved weight loss after bariatric surgery with attendance at formal support group meetings (Elakkary, et al., 2006; Hildebrandt, 1998; Nicolai, Ippoliti, & Petrelli, 2002). Support groups have been successful in improving psychological status as well as increasing adherence to dietary and exercise prescriptions postoperatively (Nicolai, et al., 2002). Elakkary et al. (2006) found significant differences in the mean weight loss after laparoscopic gastric banding between those who attended support group meetings offered and those who chose not to attend; Hildebrandt (1998) had the same findings after Roux-en-Y gastric bypass. While the role of formal support groups in the postoperative journey has been described, the role of informal support structures has not been as fully described in the current literature.

There was an identified gap in the literature investigating romantic relationships and sexual functioning after WLS. Studies identified that investigated romantic relationships and/or sexual functioning after WLS show mixed and conflicting results. In studies conducted by Rand, Kuldau, and Robbins (1982), Rand, Kowalske, and Kuldau (1984), and Goble, Rand, and Kuldau (1986), romantic relationships seemed to improve following WLS, with increases in self-esteem and physical energy, improved sexual functioning, decreased conflict, and increased marital satisfaction. Two studies concluded that there was an improvement in parts of the intimate relationships after WLS, such as the WLS individual having increased self-esteem, an improved ability to handle stress, and a more active social life, but the partners of the WLS individual report

an increase in negative behaviors, such as increased egoism, dominating behavior, and emotional instability (Kinzl, Traweger, Trefalt, & Biebl, 2003; Kinzl et al., 2001). Three studies found overall negative effects on the relationship after WLS, citing increased jealousy, increased sexual aggression by the WLS individual, increased anxiety related to control and dependency issues, and increased family workload as contributors to the worsening of the relationship (Hafner & Rogers, 1990; Marshall & Neill, 1977; Neill, Marshall, & Yale, 1978).

These major studies investigating romantic relationships and sexual functioning after WLS only used married couples as participants; there was no literature found describing what the relationship is like after WLS for same-sex couples or unmarried partners. Conducted in past decades, these studies may not be generalizable to today's couples experiencing WLS; there have been significant changes in procedural technique and the immediate postoperative recovery period that may make the experience different for today's couple versus a married couple who experienced the surgery in the 1970's or 1980's. The social construct of marriage has changed; many people today do not enter the formal contract of marriage, but prefer to live together in common-law marriages, same-sex partnerships, formal engagements, or just partnerships. People in one of these relationships may have a different experience of WLS than a married couple; this is another identified gap in the literature. This study will help fill in these gaps in knowledge by having identified the experience of WLS on one partner in a romantic relationship as well as the experience of the nonsurgical partner and the experience of the romantic dyad.

Sensitizing Framework

Bodenmann's (2005) Theory of Dyadic Coping was the theoretical framework informing this study. Bodenmann (2005) conceptualizes dyadic coping as being either positive or negative, with positive dyadic coping taking the form of problem- or emotion-focused supportive coping, problem- or emotion-focused common dyadic coping, or delegated coping, while negative dyadic coping can be conceptualized as hostile dyadic coping, ambivalent dyadic coping, or superficial dyadic coping. Dyadic coping has two main objectives: to reduce stress for each partner and to enhance the quality of the relationship. When both partners are experiencing the same stressor at the same time, dyadic coping should be able to help the couple both manage the stress, and, if the coping is positive, to enhance the togetherness and the trust, commitment, and reliability that each individual feels as part of the relationship bond (Bodenmann, 2005).

Dyadic stress is a unique concept, involving common concerns between the two individuals, the emotional intimacy between them, and the aim of continuity of the system, in other words, the continuance of the relationship (Bodenmann, 2005). Dyadic stress has three dimensions: 1) the way each partner is affected by the stressor (directly or indirectly), 2) the origin of the stress, whether it initiates from inside or outside the relationship, and 3) the time sequence, or when in the coping process does each partner become involved (Bodenmann, 1995, 1997, 2005).

Indirect dyadic stress occurs when one partner experiences a stressor alone; the other partner becomes involved when feelings of stress are expressed, either verbally or nonverbally, and dyadic coping begins; when affected by the partner's distress; or when

the stressed partner does not cope effectively with the stressor individually (Bodenmann, 2005). Direct dyadic stress is caused when both partners face a common stressor, such as illness, surgery, or the birth of a child. While each partner may experience and cope with the stressor in very different ways, both partners may share a common view of the stressor, based on the shared history of the couple (Bodenmann, 2005). The stressor can originate from within the relationship or from some external problem and can affect each partner simultaneously or at different times, which is known as sequential stress (Bodenmann, 2005).

When couples experience stress, they can choose to cope with the stress as individuals, as a dyad, or seek support from some other outside source. When coping together as a dyad, the coping mechanisms can either be positive or negative. Positive supportive coping occurs when one partner assists the other in his or her coping efforts, such as helping out with household chores, providing advice, or empathy that have the added benefit of reducing one's own stress as well as the partner's (Bodenmann, 2005). Common dyadic coping usually occurs when the stressor is a direct stressor to both partners and involves strategies such as joint problem-solving or information-seeking; both partners participate in the coping process symmetrically or complementary instead of one partner supporting the other (Bodenmann, 2005). Delegated dyadic coping involves one partner taking over responsibilities in an attempt to reduce the stress experienced by the other partner only when explicitly asked to do so (Bodenmann, 2005). Hostile dyadic coping involves mocking, disparagement, sarcasm, disinterest, or minimizing the severity of the stressful event by providing help in a negative way.

Ambivalent coping occurs when the partner supports the other unwillingly or has a lackadaisical attitude about providing the support. Superficial coping is insincere, such as asking about feelings without truly listening or supporting the partner without empathy.

Purpose of Study

Weight loss surgery produces favorable outcomes, not only in terms of weight loss and amelioration of comorbidities, but also in terms of decreased healthcare spending on obesity and its consequences, and in terms of improved psychosocial outcomes, such as enhanced quality of life, increased energy, and improved self-esteem (Bocchieri, Meana, & Fisher, 2002b; Grimaldi & Van Etten, 2010). However, the intense lifestyle restrictions and instructions can pose problems for many individuals who choose WLS. These lifestyle changes can impact relationships with family and loved ones. Therefore, the purpose of this study was to explore the experiences of both the individuals who chose WLS and their partners. Using a qualitative approach and a descriptive design, separate interviews of the WLS individuals and their partners were conducted by the researcher, which were then analyzed from the dyadic perspective to ascertain the experiences of the romantic dyad. Findings from this qualitative study provided the researcher with information about what the WLS experience was for the dyad and what data are needed for future studies to improve coping with lifestyle changes after WLS.

Research Questions

The research question was:

What is the experience of the romantic dyad after WLS?

The researcher asked one overarching interview question:

“What is your relationship like for you after having WLS?” or “What is your relationship like for you after your partner had WLS?”

Other probing questions were used after the participant finished his/her story if the concepts of stress and/or coping were not discussed. Examples of probing questions were:

“Has your relationship changed positively after the WLS? In what ways?”

“Has your relationship changed negatively after WLS? In what ways?”

“How have you overcome these issues?”

“Are there any issues regarding your relationship that you are still working on?”

“Does your partner know about these issues?”

“Has your sexual relationship changed after WLS?”

The words “stress” or “coping” were not used by the interviewer in order to get the most authentic data; introducing these words might have influenced the participants and affect their remembering of their experience (Pollio, Henley, & Thompson, 1997). The goal was a dialogue between researcher and co-researcher, or participant; asking too many questions can hinder authentic dialogue.

Definition of Terms

For the purpose of this study, the following definitions were used:

1. Romantic/intimate dyad: a romantic relationship in which both partners consider themselves to be monogamous and reside together in the same domicile. The dyad can include legal marriages, common law marriages, same sex partnerships, formal or informal engagements to be married, or a couple living together with no plans of marriage.
2. Partner: the significant other of the individual who has had bariatric surgery
3. WLS: open or laparoscopic Roux-en-Y gastric bypass

Assumptions

The following assumptions were made in this study:

1. Both individuals who have had WLS and their partners were willing to talk about their experiences as a partnered couple during the first year after WLS.
2. Weight loss surgery and the postoperative lifestyle restrictions are stressors in the romantic relationship.
3. Both the surgical individual and the partner must cope with the stress caused by the WLS and its subsequent lifestyle restrictions.
4. The stress caused by the restrictions after WLS may produce changes in the romantic relationship.

Delimitations

This study was limited to:

1. Individuals who had open or laparoscopic Roux-en-Y gastric bypass at least one year ago and no more than seven years ago. This interval is necessary in order to ensure the elicited experiences can fully describe the continuum of transformation postoperatively. This limitation of participants to individuals who have had Roux-en-Y gastric bypass contributed to a more homogenous sample.
2. These individuals must reside together, consider themselves in a monogamous romantic relationship before the surgery and continue to be in such a relationship with the same partner at the time of the study. The minimum time the couple will have been living together is one year, according to the delimitation that they will live together before the WLS, which is the minimum time postoperative to participate in the study. Therefore, the minimum time the couple must be involved romantically and living together to make a partnership is one year.
3. The surgery individuals must be at least 18 years of age, in order to elicit the experiences of adults in romantic relationships.
4. The couples must speak and understand spoken English.
5. The couples must be willing to be interviewed separately, at the time and place of their choosing, and have the interviews audiorecorded.

Significance of Study

Obesity affects every race, gender, and age. Weight loss surgery is quickly becoming an effective treatment in the fight against obesity; however, up to 20% of those

who have surgery regain the weight, wasting healthcare dollars and resources, as well as risking developing up to 30 chronic conditions associated with obesity. How WLS affects the romantic dyad is not well documented in the literature. By discovering what the experience was of the WLS individual, the partner, and the romantic dyad, and how dyadic stress and coping play a role in the continuation of the relationship, the healthcare team can understand the needs of the WLS individual and the support system. Once the needs are identified, preoperative and postoperative education and support programs can be tailored to effectively bolster the support system, in turn helping the WLS individual adhere to the lifestyle changes necessitated by the surgery.

Conceptualizing the study and analyzing the data from a dyadic perspective has implications for nursing science. Health issues rarely occur in a vacuum; more than the individual is affected. By conducting more studies from a dyadic perspective, the researcher can effectively describe the experiences of both members of the dyad and perform interventions aimed at improving the situation for both partners, not just the individual with the health concern.

Summary

Weight loss surgery is an effective tool for weight loss in morbidly obese individuals; more morbidly obese individuals are choosing WLS as a long-term method of losing weight and improving health. Choosing WLS necessitates radical lifestyle changes that are medically recommended to be followed for the individual's lifetime. How these lifestyle changes affect romantic dyads has not been thoroughly identified;

therefore, this study used a qualitative descriptive approach to explore the experiences of WLS individual, the partner, and the romantic dyad after WLS.

This chapter has provided an overview of the study and the unique contribution to nursing science this study will provide. Guided by Bodenmann's (2005) Theory of Dyadic Coping, the researcher gained an understanding of how the romantic dyad copes with the inherent stress caused by the surgery and the subsequent lifestyle changes. Understanding how the romantic dyad is affected after WLS may enable nurses to develop interventions and appropriate education, which can be implemented preoperatively and postoperatively to maximize coping and weight loss.

CHAPTER II

LITERATURE REVIEW

Introduction

In order to examine the literature surrounding the meaning of WLS for the romantic dyad, where one person has had bariatric surgery and the other person has not, five major areas of literature will be reviewed. First, the meaning of obesity, from both the medical perspective and the individual perspective, will be reviewed. While this will not be an exhaustive review, it will provide an understanding of what it means to be obese in today's society. The second and third sections will narrow the focus of the literature to WLS, namely the history, types of procedures, and finally, physical and psychosocial outcomes. Next, studies that represent the bariatric surgery experience for the patient and the family will be reviewed. Finally, the literature focusing on dyadic coping – how couples as one unit cope with chronic illness – will be explored. Obesity continues to grow as a major health threat in the United States, and more people turn to surgery as a treatment. This study seeks to contribute to current literature by gaining an understanding of how WLS affects the romantic dyad.

Meaning of Obesity

Obesity, as defined by the Centers for Disease Control and Prevention is the state of weighing more than is generally considered healthy for height (Centers for Disease Control and Prevention, 2010b), or an unhealthy accumulation of body fat (World Health

Organization, 2010). Most disciplines use the categories overweight, obese, and morbidly obese to further describe this phenomenon. Overweight persons have a body mass index (BMI) of 25 to 29.9 kg/m², while those classified as obese have BMIs from 30 kg/m² and higher (U. S. Department of Health and Human Services Agency for Healthcare Quality and Research, 2010). Further classifications of obesity based on BMI are as follows: class I obesity is defined as having a BMI 30-34.9 kg/m²; class II is a BMI 35-39.9 kg/m², and class III is a BMI of 40 kg/m² and above (U. S. Department of Health and Human Services Agency for Healthcare Quality and Research, 2010). To those who live with obesity or morbid obesity, however, these definitions do not accurately describe the emotions, the physical pain, and the shame that often goes along with being obese. Obesity affects every race and culture in every nation worldwide. It is not a gender specific phenomenon. No socioeconomic class is exempt.

Medicine's Meaning of Obesity

Medicine has, more than any other entity, defined, conceptualized, and measured obesity and overweight. Medicine has clearly documented the inherent risk factors of obesity for developing serious chronic diseases, like diabetes, hypertension, heart disease, stroke, fatty liver disease, and hyperlipidemia (Spiotta & Luma, 2008). Medicine and the Centers for Disease Control and Prevention (CDC) have categorized the levels of obesity (classes I, II, and III) by the corresponding BMI measurements as described.

The American Medical Association (AMA) convened a national summit in 2004 on obesity. Kushner (2003) in conjunction with the Robert Wood Johnson Foundation and the AMA published a primer for physicians on how to properly evaluate patients for

overweight and obesity and called for BMI and waist circumference to be classified as the sixth Joint Commission vital sign. The report published from the 2004 national summit discussed community, school, worksite, and medical practice interventions to identify and treat patients with obesity (American Medical Association, 2004). In this report, the AMA (2004) also called for obesity to be classified as a disease and not just a condition and concluded that no one entity by itself, not physicians, not schools, not the community, by themselves, can do something constructive about the national epidemic of obesity. Perhaps in response to this call from the AMA, in 2004, Medicare declared obesity as a condition with allowed coverage and removed statements from the Medicare Coverage Issues Manuals stating obesity was not an illness (Lee, Sheer, Lopez, & Rosenbaum, 2010). In February, 2006, the Centers for Medicare and Medicaid Services (CMS) established a national coverage policy for WLS to help reduce significant health risks associated with obesity, including death and disability (Centers for Medicare & Medicaid Services, 2006). Diabetes was specified to be a comorbidity of obesity that would be allowed to determine coverage for WLS by CMS in 2009 (Centers for Medicare & Medicaid Services, 2009). Only by collaborating and developing programs together can organizations provide obese persons with the support and resources necessary to begin the journey towards a healthier life.

Costs of Obesity. The healthcare costs of obesity are staggering. In the United States, employers are spending over \$900 billion on healthcare annually, with obesity costing employers over \$75 billion annually (American Society for Metabolic and Bariatric Surgery; Gates, Brehm, Hutton, Singler, & Poepelman, 2006). Obesity-related

costs can consume anywhere from 2% to 7.8% of total health care expenditures for U. S. businesses (Gates, et al., 2006). Based on recent data, the total medical expenses attributed to obesity range from \$93 billion to \$147 billion annually (Centers for Disease Control and Prevention National Center for Chronic Disease Prevention and Health Promotion, 2010; Kessler & Eckstein, 2005). Obese individuals spend 36% more on health care, an equivalent of \$1400 more per year in 2006 (Centers for Disease Control and Prevention National Center for Chronic Disease Prevention and Health Promotion, 2010), and 77% more on medications than individuals of normal weight (American Society for Metabolic and Bariatric Surgery). Not only is obesity partly responsible for the skyrocketing costs of healthcare for U.S. businesses, but one must also factor in the costs of increased absenteeism, decreased productivity, and increased presenteeism, where the employee is present at work but is either too ill or physically unable to be considered productive (Batt, 2009; Gates, et al., 2006).

Psychology's Meaning of Obesity

The field of psychology conceptualizes obesity as a root cause of psychosocial dysfunction. Psychology literature aims to describe how obesity affects the psyche, as well as aiming to determine if a brain abnormality is a factor in becoming overweight. Merten, Wickrama, and Williams (2008) reviewed data obtained from adolescents from Waves 1 and 3 of the National Longitudinal Study of Adolescent Health and concluded that obese females achieve less social status, have more depressive symptoms, are less likely to enroll in college or even aspire to obtain a higher degree, regardless of their qualifications, and may leave high school early due to the stigma of obesity. Employment

status is also affected; obese females have higher unemployment rates, more work limitations, and lower earnings when compared to their normal weight peers (Merten, et al., 2008). Obese females were found to have fewer career options, less pay, less opportunity for advancement, more reprimands and terminations, and fewer career choices than ex-convicts and people with a history of mental illness (Merten, et al., 2008). Interestingly enough, obese men did not have an association with these lower psychosocial outcomes. Obese women face more stigmatization and oppression in all aspects of life than do their obese male counterparts.

In determining if obesity may have a physical etiology researchers have determined that there are differences in cerebral chemical compositions between obese and normal weight individuals. Stice, Spoor, Bohon, Veldhuizen, and Small (2008) conducted a magnetic resonance imaging study of 33 adolescent girls ranging from lean to obese. The obese girls had more brain activity to the anticipated reward of a chocolate milkshake than to the neutral taste saliva solution than the normal weight or lean girls (Stice, et al., 2008). This study did have its limitations; males were not tested, and only one taste, chocolate milkshake, was tested. However, it is important to realize that perhaps the urge to overeat may be chemically driven and not just emotionally or behaviorally driven.

Nursing's Meaning of Obesity

The nursing profession, according to current research, does not view obesity any differently than any other healthcare related discipline (Reedy & Blum, 2010). The definitions of obesity are the same, and much of the research is geared towards interventions that reduce the risk of obesity and improve fitness and nutrition. One area

of research that is different is the effects of caring for heavier clients on nurses. From specialized beds and lifts to protocols for moving, transporting, and transferring care of bariatric clients, nurses are doing what they can to protect themselves from injury while providing compassionate care to these clients (Roland, Howes, Stickles, & Johnson, 2010; Scott, Pokorny, Rose, & Watkins, 2010).

Healthcare professionals tend to define obesity as a measure of body mass, strictly relying on weight and BMI, and the resulting comorbidities associated with obesity. To psychologists, obesity could have a physical, biochemical etiology and has far-reaching psychosocial implications. For nursing, obesity means challenges to providing routine care. Obesity for the person can mean something else entirely.

Meaning of Obesity for Obese Persons

Stigma, shame, and embarrassment are daily occurrences for obese persons. Phenomenological studies of obese persons show common experiences of embarrassment and stigmatization, such as trying to fit into physical spaces (Merrill & Grassley, 2008; Rogge, et al., 2004), being dismissed or treated less than human (Merrill & Grassley, 2008; Rogge, et al., 2004; Thomas, Hyde, Karunaratne, Herbert, & Komesaroff, 2008), and trying to denounce stereotypes of being lazy or being made to feel blame (Merrill & Grassley, 2008; Puhl & Brownell, 2006; Puhl, et al., 2008; Rogge, et al., 2004; Thomas, et al., 2008; Wright & Whitehead, 1987).

It may be surprising to note that in most studies, the stigmatizing incidents were most often in encounters with family, friends, and healthcare professionals (Merrill & Grassley, 2008; Puhl & Brownell, 2006; Puhl, et al., 2008; Rogge, et al., 2004; Thomas,

et al., 2008). Obese individuals are made to feel abnormal and inferior everyday by those who profess to love, like, care about, or swear to provide healthcare to all people (Rogge, et al., 2004). Embarrassing or humiliating experiences with healthcare providers were described in several studies (Merrill & Grassley, 2008; Puhl & Brownell, 2006; Rogge, et al., 2004; Thomas, et al., 2008). These findings support Drury and Louis' (2002) conclusions that increased BMI is associated with an increase in avoiding or delaying health care.

Disparaging attitudes, stigmatization, and discrimination against obese persons have been revealed in studies of Registered Nurse students (Culbertson & Smolen, 1999), Registered Nurses (Gujral, Tea, & Sheridan, 2011; Zuzelo & Seminara, 2006), psychologists (Davis-Coelho, Waltz, & Davis-Coelho, 2000), exercise science students (Chambliss, Finley, & Blair, 2004), physician assistant students (Wolf, 2010), fitness professionals (Puhl & Wharton, 2007), and researchers specializing in obesity research (Schwartz, Chambliss, Brownell, Blair, & Billington, 2003). A study by Puhl and Brownell (2001) revealed that physicians, nurses, teachers, employers, and parents overtly and covertly discriminate against obese persons. However, Puhl, Schwartz, and Brownell (2005) discovered that attitudes towards obese people improve, negative stereotypes decrease, and positive stereotypes increase after learning that other people held better opinions of obese people. This finding has important implications for the healthcare industry. If healthcare providers and other professionals could display more positive attitudes towards obese people, one may conclude that more obese people would seek treatment.

Prejudice and bias toward obese people are so pervasive that several instruments have been developed and tested to measure these negative attitudes. Lewis, Cash, Jacobi, and Bubb-Lewis (1997) constructed and developed the Antifat Attitudes Test (AFAT), which was found to have three subscales: social/character disparagement, physical/romantic unattractiveness, and weight control/blame. In this study, men were found to have more negative attitudes toward obese persons than women.

University students were surveyed to determine their feelings of bias toward obese persons as compared with gay persons and Muslim individuals (Latner, O'Brien, Durso, Brinkman, & MacDonald, 2008) with three versions of the Universal Measure of Bias (UMB), each focusing on obese, gay, or Muslim people. Weight bias was more prevalent and significantly stronger than other tested bias targets. The UMB was determined to have excellent psychometric properties and can be adapted to investigate prejudice against many different groups and over time (Latner, et al., 2008).

Allison, Basile, and Yuker (1991) constructed and tested two obesity attitude scales: the Attitudes Toward Obese Persons Scale (ATOP) and the Beliefs About Obese Persons Scale (BAOP). These two instruments were designed to accurately measure attitudes and beliefs about obese persons, as there was a previous lack of psychometrically sound instruments designed to measure these constructs. Both scales were found to have sound psychometric properties and a simple factor structure upon analysis. Findings concluded that beliefs about obese persons are consistent and strongly correlated with attitudes toward obese persons, meaning that beliefs are a major determinants of attitudes (Allison, et al., 1991).

Obesity, for obese persons, means bias, shame, embarrassment, discrimination, and disparagement. Obesity can also lead to sexual dissatisfaction and dysfunction for men and women. The majority of these negative attitudes and feelings come from the people considered to be in the closest relationships with the obese individual: friends and family. Another population that has disparaged the obese person is healthcare providers (Davis-Coelho, et al., 2000; Puhl & Brownell, 2001; Zuzelo & Seminara, 2006). Obesity bias is so pervasive that several instruments have been developed to adequately measure negative attitudes and beliefs about obese people. With so much negativity, many obese people turn to WLS as a treatment option.

Obesity and Sexual Functioning

Obesity has been linked to sexual dysfunction. Obese individuals experience poor body image and decreased self-esteem. Participants who had higher levels of self-esteem had better sexual functioning in a study of college men and women (N=263) (Cash, Maikkula, & Yamamiya, 2004). This study reports that both sexes who reported self-consciousness during sexual relations focused substantially on weight as the primary cause of their self-consciousness (Cash, et al., 2004). Researchers in France performed a national survey of sexual behaviors (N=12,364) and concluded that obese women were less likely than normal weight women to report having had a sexual partner in the past year, were less likely to seek contraception from healthcare workers, and more likely to have unplanned pregnancies, while obese men report less sexual partners in the past year than normal weight men and experience increased erectile dysfunction (Bajos, Wellings, Laborde, & Moreau, 2010). Higher BMI has been associated with lack of enjoyment of

sexual activity, lack of sexual desire, difficulties with sexual performance, and avoidance of sexual encounters; these sexual dysfunctions were more associated with obese women than men (Kolotkin et al., 2006; Ostbye et al., 2011). Severely obese men who experience sleep apnea have decreased testosterone levels and associated decreased sexual quality of life (Hammoud et al., 2011).

Surgical Treatment for Obesity

Weight loss surgical procedures are among the few current treatments that produce long-term significant weight loss. Surgical procedures are restrictive, reducing the size of the stomach and therefore the intake of food; malabsorptive, reducing the ability of the intestine to absorb nutrients; or both. The following section offers a brief history of weight loss surgical procedures.

History of Weight Loss Surgical Procedures

In 1954 the first jejunoileal bypass surgery was performed; this surgery bypassed a large segment of the small intestine by connecting the proximal small intestine to the distal small intestine (Maggard et al., 2005). Weight loss occurred secondary to malabsorption due to the absence of pancreatic and biliary enzymes; however, major complications of chronic diarrhea, nutritional deficiencies, renal stones, irreversible cirrhosis, and death led to the discontinuation of this procedure (Bult, van Dalen, & Muller, 2008; Maggard, et al., 2005).

In the late 1970s, the biliopancreatic diversion was performed as an alternative to the jejunoileal bypass (Buchwald, Cowan, & Pories, 2007). This surgery involves removing all but 100-150mL of the stomach, which is connected to either the jejunum or

ileum, where the biliopancreatic limb is also reanastomosed (Buchwald, et al., 2007; Bult, et al., 2008). Ulceration of the small intestine is a major complication, as the jejunum and ileum are less tolerant of gastric acids than the duodenum (Buchwald, et al., 2007). The biliopancreatic diversion with duodenal switch is a modification aimed at decreasing this complication. In this procedure, first performed in 1986, the stomach pouch is much smaller, similar to the 30 mL pouch formed in the gastric bypass, and is connected to a very small (2cm) portion of duodenum before being anastomosed to the distal jejunum or ileum (Bult, et al., 2008). The malabsorption is similar, yet less ulceration occurs (Buchwald, et al., 2007). These procedures have the highest reported weight loss of all procedures but also have the highest incidence of complications, especially nutritional deficiencies (Buchwald, et al., 2007).

In the early 1980s, stomach staplers led to restrictive gastroplasty procedures, in which the upper portion of the stomach was stapled into a small pouch with a small outlet to the remaining stomach, leading to an early feeling of fullness and smaller meal consumption (Maggard, et al., 2005; Mitchell & de Zwaan, 2005). Complications included staple-line breakdown and stoma enlargement, leading to weight regain; surgical modifications included the placement of a band around the stoma to prevent stretching of this opening in a procedure now known as the vertical banded gastroplasty (Maggard, et al., 2005; Mitchell & de Zwaan, 2005). The vertical banded gastroplasty is decreasing in popularity due to the advances in the laparoscopic adjustable gastric banding procedure.

The vertical sleeve gastrectomy, first performed in Australia in 1993, is a procedure that is gaining more favor worldwide; currently only about 20 surgeons

worldwide perform this surgery (Buchwald, et al., 2007). This procedure staples the stomach vertically into a pouch shaped like a small banana, from the esophageal sphincter to the pyloric sphincter, and removes approximately 85% of the stomach (Buchwald, et al., 2007). This is a purely restrictive procedure. Recommended as the first of a two-stage WLS option for the super-morbidly obese, the vertical sleeve gastrectomy is a safer option than a malabsorptive procedure for the individual weighing over 500 lbs (Buchwald, et al., 2007). The WLS individual can lose up to 200 lbs after the vertical sleeve gastrectomy and significantly reduce comorbidities, thereby rendering them eligible for a second trip to the operating room for a malabsorptive procedure, such as the gastric bypass (Buchwald, et al., 2007). However, the increased technical demands of the surgery, increased complication rate, and increased mortality rate, due in part to the super morbid obesity of the surgical individual, make this procedure much more risky than others (Buchwald, et al., 2007).

The first gastric bypass was performed in 1967 and combined the restrictive properties of a small gastric pouch with malabsorptive properties caused by bypassing a portion of the duodenum (Maggard, et al., 2005). Over the past four decades, modifications have been made to this surgical procedure, resulting in the Roux-en-Y gastric bypass (RYGB). The RYGB involves stapling the stomach into a 30-mL pouch (restrictive) and separating this pouch from the rest of the stomach; the Roux-en-Y limb restores continuity by connecting the stomach pouch to the jejunum (malabsorptive) (Bult, et al., 2008; Maggard, et al., 2005). The RYGB can be performed either via an open procedure or laparoscopically. The RYGB is the most common weight loss

procedure performed in the United States to date (Bult, et al., 2008; Maggard, et al., 2005; Yaskin, Toner, & Goldfarb, 2009).

In 1992, the first laparoscopic adjustable gastric banding (LAGB) was performed (Mitchell & de Zwaan, 2005). This procedure proved to be simpler to perform than other restrictive or malabsorptive procedures; it incurs less postoperative complications and is the only surgery that is easily and completely reversible (Bult, et al., 2008). A silicon inflatable band is placed horizontally around the proximal end of the stomach, and a port is placed subcutaneously for adjusting the band. Adjusting the band is necessary when the gastric stoma becomes too large, leading to increased gastric emptying and increased feelings of hunger; likewise, if the individual experiences reflux or excessive vomiting, the band can be deflated to increase stoma size and relieve symptoms (Bult, et al., 2008). However, the amount of excess weight lost with the adjustable gastric banding is less than with RYGB or other malabsorptive procedures. Several meta-analyses report less weight loss after laparoscopic adjustable gastric banding than RYGB; 47.5% (LAGB) versus 61.6% (RYGB) (Buchwald et al., 2004); $18 \pm 11\%$ (LAGB after 15 years) versus $27 \pm 12\%$ (RYGB after 15 years) (Bult, et al., 2008); and 30.19 kg (LAGB after 12 months) versus 43.46 kg (RYGB after 12 months) (Maggard, et al., 2005). Compared with standard care, the differences in BMI levels from baseline in one year (15 trials; 1103 participants) were as follows: biliopancreatic diversion (-11.2 kg/m^2), sleeve gastrectomy (-10.1 kg/m^2), Roux-en-Y gastric bypass (-9.0 kg/m^2), and adjustable gastric banding (-2.4 kg/m^2) (Padwal et al., 2011).

Postoperative Lifestyle Changes

Postoperative dietary restrictions can be overwhelming to the new WLS individual, especially in the first three months after surgery. While postoperative regimens vary from practice to practice, the following example is a general dietary overview after WLS, regardless of type.

LAGB individuals may start clear liquids on the day of surgery, depending on the practice (Grindel & Grindel, 2006). For RYGB individuals, nothing is allowed by mouth on the day of surgery. Clear liquids are usually started on the first postoperative day at 0600; 30 mL of water is provided hourly for the first four hours of taking fluids (Dr. Roc Bauman, personal communication, January 5, 2011). After four hours of water, if the person is tolerating fluids without symptoms of bloating, nausea, or vomiting, at 1000 the diet is progressed to 30 mL of water and 30 mL of a sugar-free high protein shake every hour (Dr. Roc Bauman, personal communication, January 5, 2011). While some practices allow sugar-free gelatin, sugar-free pudding or yogurt in the early postoperative period (Grindel & Grindel, 2006), more conservative practices maintain the WLS individual on 1 oz of clear liquids (caffeine & sugar-free) and 1 oz of protein shake hourly for two weeks, with the daily goal intake equaling 60 g of protein via shakes (Dr. Roc Bauman, personal communication, January 6, 2011).

Phase 3 of the postoperative dietary regimen allows pureed foods to be added to the meal plans. Again more conservative practices only allow high protein pureed foods, such as fat-free refried beans, pureed pinto beans, fat-free cottage cheese, black bean soup, navy bean soup, or any lean meat pureed to a liquid consistency to be ingested for

the next two weeks, and absolutely no “white” foods that offer little to no nutritional benefit, such as potatoes, rice, bread, and pasta (Dr. Roc Bauman, personal communication, January 20, 2011). Less conservative practices allow such foods as mashed potatoes, pureed vegetables or fruit (no peels), grits, or cream of wheat on the meal plan for this phase (Grindel & Grindel, 2006). No more than 2 oz (1/4c) may be ingested at any one time. During this phase, the person begins to assimilate their dietary restrictions into 3 small meals and 1-2 smaller snacks. As before, the daily goal is at least 60 g of protein and 60 oz of sugar-free, caffeine-free clear liquids.

Phase 4 typically lasts 2-4 weeks; now the individual can begin incorporating meats slowly into the diet without pureeing them. Dr. Bauman recommends adding fish and seafood the first week, followed by chicken the second week, then lean pork, and finally lean beef on the fourth week (personal communication, February 1, 2011). Other practices incorporate well cooked pasta and rice, toasted breads, crackers, well-cooked vegetables, soft fruits without skin or peel, and other soft foods into the meal plan; 70% of each meal should be protein, and the protein must be eaten first (Grindel & Grindel, 2006). The daily fluid and protein intake goals remain the same.

Phase 5 can be considered the maintenance phase; the meal plan now includes everything that the post-surgical individual can eat. It may be easier to list what the person cannot eat now: anything with sugar, alcohol, soft breads that become gummy, vegetables/fruits with tough skins or seeds, tough meats or meats with gristle, and fried foods (Grindel & Grindel, 2006). The pouch can now hold 3-4 oz, so protein should

equal 2-3 oz with vegetables or fruit equaling 1 oz per meal. Fluids should still equal 60 oz, and protein intake should equal or exceed 60 g per day.

Vitamin supplementation is vital in preventing deficiencies. The adult WLS individual must take a multivitamin daily for life; most bariatric practices recommend an adult chewable multivitamin to aid in absorption (Koch & Finelli, 2010). Calcium and Vitamin D deficiencies have been documented in the WLS population, therefore calcium supplementation of at least 1200mg daily and Vitamin D supplementation of at least 2000 IU daily is recommended (Koch & Finelli, 2010). Calcium carbonate is not as easily absorbed and must be taken with food; therefore calcium citrate is recommended, as are chewable calcium supplements (Dr. Roc Bauman, personal communication, January 12, 2011). If a multivitamin specifically formulated for the WLS individual is taken, then other supplementation may not be necessary; if not, most surgeons recommend a B-complex supplement daily as well (Diane Stout, RN, personal communication, March 8, 2011). For those individuals with a history of anemia, daily iron supplementation may be prescribed as well (Koch & Finelli, 2010).

Daily exercise is an important part of the lifestyle modifications necessary after WLS. Exercise begins the day of surgery; most individuals must walk around the nursing unit on the evening of surgery (Grindel & Grindel, 2006). Upon discharge, bariatric practices encourage 20-30 minutes of walking per day, which can be separated into two or three 10-minute intervals (Grindel & Grindel, 2006); however, more conservative practices mandate 60 minutes of activity at least 6 days per week beginning at discharge and continuing for life (Dr. Roc Bauman, personal communication, January 5, 2011).

For the morbidly obese individual, dealing with these lifestyle changes may present some stress. Meals now have to be planned in advance in order to ensure adequate protein intake and the availability of allowed foods. Finding time for meal planning and the exercise requirements may place stress on both the WLS individual and on the romantic dyad, as the partner must also cope with these changes.

Physical Outcomes

Weight Loss. Five major meta-analyses of WLS have all concluded that WLS is more effective at producing and maintaining long term weight loss than non-surgical weight loss methods such as medication or diet and exercise-based programs (Buchwald, et al., 2004; Buchwald et al., 2009; Bult, et al., 2008; Maggard, et al., 2005; Yaskin, et al., 2009). The most often quoted figure states the overall percentage of excess weight loss for 10,172 individuals regardless of surgery type was 61.2% (95% CI, 58.1% - 64.4%) (Buchwald, et al., 2004). In most cases, weight loss outcomes did not differ significantly for weight assessments made at two years or less postoperatively than with those at greater than two years postoperatively (Buchwald, et al., 2004). For those meta-analyses that considered weight loss differences among the different surgery types, conclusions were that the biliopancreatic diversion individuals experienced the greatest weight loss, followed by RYGB individuals, and purely restrictive surgeries (LAGB, vertical banded gastroplasty) producing the least amount of weight loss (Bult, et al., 2008; Maggard, et al., 2005; Yaskin, et al., 2009).

Amelioration of Comorbidities. Weight loss surgery can dramatically improve, or resolve, many of the comorbidities associated with obesity. Type II diabetes, one of

the most costly, disfiguring, disabling, and deadly diseases associated with obesity can be improved or resolved completely after WLS. Buchwald et al. (2009) concluded in their meta-analysis that 78.1% of WLS individuals with diabetes had complete resolution, and 86.6% of individuals showed improvement in their fasting blood sugar and hemoglobin A₁C values. It is interesting to note that weight and Type II diabetes do not have a direct cause-and-effect relationship; many WLS individuals experience resolution of their Type II diabetes within days after RYGB, before significant weight loss occurs (Buchwald, et al., 2009). Bult et al. (2008) concluded in their meta-analysis that only about 36% of these individuals with diabetes resolution continue to be free from the disease at 10 years postoperatively.

Hypertension, hyperlipidemia, obstructive sleep apnea, gout, and polycystic ovarian syndrome are also greatly improved after WLS. Correlations between WLS and reduction in comorbidities are significant: hypertension is resolved in 61.7% of WLS individuals, and obstructive sleep apnea is resolved in 85.7% of individuals (Buchwald, et al., 2004; Bult, et al., 2008; Maggard, et al., 2005; Yaskin, et al., 2009). Lipid levels improve in 60-100% of individuals with pre-existing hyperlipidemia (Maggard, et al., 2005). Individuals with polycystic ovarian syndrome experienced improvements in hirsutism, hyperandrogenemia, insulin resistance, and ovulation and/or restoration of the menstrual cycle (Bult, et al., 2008).

Weight loss surgery has been shown to be effective at helping morbidly obese persons lose a significant percentage of excess weight and improve comorbidities.

Complications from surgery can occur and can be fatal. The following section outlines the most common surgical complications after WLS.

Complications

Mortality. Operative mortality, or death within 30 days of surgery, is between 0% for restrictive procedures and 2.0% for biliopancreatic diversions with or without duodenal switch procedures (Buchwald, et al., 2004; Bult, et al., 2008; Maggard, et al., 2005). Mortality after 30 days varies between 0.1 and 4.6%, depending on the procedure and individual characteristics, with malabsorptive procedures having increased mortality (Bult, et al., 2008). Bult et al. (2008) concluded from their meta-analysis that age over 65 years, male gender, decreased peak oxygen consumptions, and surgeon inexperience contributed significantly to increased mortality rates. Pulmonary embolism is the leading cause of death after RYGB, causing 80% of deaths (Bult, et al., 2008).

Postoperative Complications. Complications after WLS can vary in severity, from mild to fatal. While there are some procedure-specific complications, there are some adverse events that are common to all WLS procedures. Obese individuals are more at risk of developing complications postoperatively, especially related to anesthesia and intubation and/or extubation difficulties (Buchwald, 2005; Bult, et al., 2008).

Venous thromboembolism can be a deadly complication after WLS. Obese individuals are at greater risk, as are those individuals having abdominal surgery, for developing deep vein thromboses (DVT); therefore, adequate thromboprophylaxis should be initiated with early ambulation, compression hose, sequential compression devices, and daily doses of enoxaparin (Bult, et al., 2008). Sepsis, resulting from infection around the

adjustable band, incision, or from an anastomotic leak, is another deadly complication and can occur in ~0.5-3% of procedures (Bult, et al., 2008). Hemorrhage is always a complication after any type of surgery; there is no data to suggest WLS individuals are at higher risk for hemorrhage than those having other procedures (Buchwald, 2005).

Common Complications. Milder symptomatic complications can range from nausea and vomiting to dumping syndrome in both restrictive and malabsorptive procedures. Dumping syndrome can occur in both restrictive and malabsorptive procedures, but is most common in RYGB individuals (up to 50%) (Bult, et al., 2008) and is a result of food rapidly passing into the intestine, causing an increased amount of water to be pulled into the intestine, pushing food too rapidly down the tract (Grindel & Grindel, 2006). This increased peristalsis causes a rapid heart rate, sweating, dizziness, weakness, diarrhea, nausea, and abdominal cramping. The ingestion of foods high in sugar is the culprit in dumping syndrome in most cases; dumping syndrome is normally resolved after a year postoperatively as the body has adjusted to the changed gastrointestinal tract and the person makes the proper dietary changes (Grindel & Grindel, 2006).

Cholelithiasis is related to increased amounts of weight loss; the incidence of gallstones after WLS ranges between 22 and 71% with 7-41% having symptoms, necessitating a cholecystectomy (Bult, et al., 2008). If the WLS individual has gallstones preoperatively, a cholecystectomy performed with or before the WLS is recommended, and Bult et al. (2008) conclude that a cholecystectomy is a reasonable option in all open WLS procedures.

Large skin folds occur after major weight loss and often require plastic body-recontouring surgery. An abdominal panniculus, or apron of fat and excess skin that hangs down from the lower abdomen, can cause skin irritations and back problems as well as increasing the risk of hernias due to the instability of the abdominal wall (Grindel & Grindel, 2006). The panniculus can range in size from barely covering the pubic hairline and mons pubis to covering the knees and beyond. Surgeons can perform a panniculectomy at two to three years postoperatively; however, complications such as wound infections, skin necrosis, respiratory distress, and hematoma formation can occur, and insurance frequently will not cover these recontouring surgeries (Grindel & Grindel, 2006).

Procedure-Specific Complications. Malabsorptive procedures have increased risk of complications due to the increased difficulty of the procedure. Anastomotic leaks range in incidence from 1.0-2.2% (Maggard, et al., 2005) and can lead to peritonitis, sepsis, and death. Anastomotic stenosis can cause vomiting due to outlet obstruction in up to 20% of individuals having malabsorptive procedures; stenosis can lead to increased malabsorption (Bult, et al., 2008). A newly described complication after RYGB is nesidioblastosis, a condition involving the pancreatic beta cells in which too much insulin is produced, causing chronic hypoglycemia; this condition is thought to be caused by much the same intestinal hormonal mechanism that resolves Type II diabetes so rapidly after RYGB surgery (Bult, et al., 2008). Abdominal hernias are increasingly common after malabsorptive procedures, with incisional hernia being more common after open

procedures, and internal hernias occurring more frequently after laparoscopic procedures (Maggard, et al., 2005).

Nutritional and vitamin deficiencies can occur after either restrictive or malabsorptive procedures, but are more common after malabsorptive surgeries. Common nutritional deficiencies after WLS include protein, iron, vitamin B₁₂, thiamine, folate, calcium, and the fat-soluble vitamins (A, D, E, and K) (Grindel & Grindel, 2006; Koch & Finelli, 2010; Maggard, et al., 2005). These deficiencies can lead to microcytic (due to low iron levels) and macrocytic (due to decreased vitamin B₁₂ or folate levels) anemia, bone metabolism problems such as osteomalacia and osteoporosis, peripheral neuropathies from decreased thiamine or vitamin E, visual disturbances from lack of vitamin A, skin problems such as xerosis and pruritis from essential fatty acid, niacin, and riboflavin deficiencies, and edema from hypoalbuminemia (Grindel & Grindel, 2006; Koch & Finelli, 2010).

Restrictive procedures have fewer complications. There are unique long-term complications of LAGB; these include gastric prolapse, stomal obstruction, esophageal and gastric pouch dilation, gastric erosion and necrosis, and subcutaneous port access problems including tubing disconnection between the band and the port (Buchwald, 2005; Bult, et al., 2008). By using the silicone band, a foreign object is introduced into the body, increasing the risk of infection and chronic inflammation (Buchwald, 2005). However, if symptoms prove to be more problematic than what the individual is willing to endure, the band, tubing, and port can be completely removed. The option of having further WLS in the form of RYGB or a biliopancreatic diversion can be entertained if

long-term weight loss is not achieved. Individuals who have had vertical banded gastroplasty have a high incidence of persistent (longer than 10 years) postoperative vomiting (20%) and gastroesophageal reflux disease (16%). If the symptoms are too severe, conversion to a RYGB may be considered.

In conclusion, the mortality rate after WLS can be considered low, considering the increased risk of the morbidly obese patient. Complications can occur, which can range in severity from mild to fatal. Age, surgeon ability, and adherence to the postoperative recommendations can help decrease the incidence of complications.

Psychosocial Outcomes

Weight loss surgery is not a “quick fix” for instant weight loss. Surgery is a tool designed to aid morbidly obese individuals in weight loss and improving health status. Postoperatively, bariatric surgery patients must adjust to drastic lifestyle changes, especially regarding food intake and exercise recommendations. It is understandable to expect that bariatric surgery patients will have periods of emotional peaks and valleys during this drastic adjustment. The following sections explore the documented psychosocial outcomes following weight loss surgery. Psychosocial outcomes following bariatric surgery will be classified by outcomes related to stigmatization and discrimination, psychopathology, self-concept, binge-eating behavior, and marital adjustment/sexual functioning.

Stigmatization and Discrimination. People who have had weight loss surgery have reported increases in social contacts, social activities, and employment opportunities postoperatively (Bocchieri, et al., 2002b; Wolfe & Terry, 2006). This increase in social

connectedness may be due to decreased stigmatization and discrimination because of the weight loss; however, other factors may also be partly causative, such as increased self-esteem, increased assertiveness, better physical health, and improved self-confidence (Bocchieri, et al., 2002b). Grimaldi and Van Etten (2010) state that many patients do not disclose about undergoing bariatric surgery to any but the closest of relatives; Sutton, Murphy, and Raines (2009a) report that this nondisclosure is due to stigmatization, ridicule, and prejudice from patients' friends and family. Patients were made to feel like they were taking the easy way out by their loved ones for having weight loss surgery; patients also were afraid of yet another failure in their attempt at permanent weight loss and therefore did not want anyone else to know of their decision (Sutton, et al., 2009a).

Other negative social outcomes have been reported by bariatric surgery patients including changing social circles and difficulty adjusting to their newfound social acceptability (Bocchieri, et al., 2002b). Social relations (family, friends, coworkers) may be envious or jealous of the patient's rapid weight loss (Bocchieri, et al., 2002b; Grimaldi & Van Etten, 2010). The bariatric surgery patient may also have negative feelings about being accepted socially now that weight loss has occurred (Bocchieri, et al., 2002b). More research needs to be done to examine potentially negative social outcomes of bariatric surgery, as this is a gap in the literature.

Psychopathology. In a study investigating 90 surgical candidates, 66% of candidates for bariatric surgery had a psychiatric diagnoses and almost 40% were currently undergoing some treatment for their psychiatric diagnosis (Sarwer et al., 2004). Depression was the main Axis I diagnosis in this study. Kalarchian et al. (2007)

evaluated lifelong psychopathology in 288 bariatric surgery candidates and concluded that 42% reported depression, 37.5% anxiety disorders, 32.6% substance abuse disorders, 17% avoidant personality disorders, and 11% posttraumatic stress disorders (PTSD). Pomerantz (2007) documented less depressive episodes and decreased severity of symptoms in bipolar patients after bariatric surgery. Sexual abuse has been reported in morbidly obese patients, and PTSD symptoms can occur after rapid weight loss (Grimaldi & Van Etten, 2010). While most patients report increased feelings of happiness, improved mood, increased self-esteem, and better psychological functioning after surgery, some patients experience problems coping and an increase in psychological dysfunction postoperatively (Grimaldi & Van Etten, 2010). Toussi, Fujioka, and Coleman (2009) stated that depression, among other factors, was associated with increased incidence of missed appointments and increased BMI postoperatively. Individuals with addictions may also experience transference of the addiction to food to another substance or habit, such as gambling, shopping, or illicit drug addictions (Grimaldi & Van Etten, 2010; Warren & Gold, 2007). Psychiatric providers dealing with this population have the obligation to monitor for psychiatric issues and symptoms postoperatively, and the patient/family should be educated regarding the possibility of a recurrence of psychiatric symptoms.

Self-Concept. Factors leading to improved self-concept, improved mood, and increased self-efficacy are self-esteem, self-confidence, assertiveness, and body image. All studies measuring these concepts have documented improvements in self-esteem, confidence, assertiveness, and body image satisfaction (Bocchieri, Meana, & Fisher,

2002a; Bocchieri, et al., 2002b; Grimaldi & Van Etten, 2010; Sutton & Raines, 2007; van Hout, Hagendoren, Verschure, & van Heck, 2009; Zijlstra, Larsen, de Ridder, van Ramshorst, & Geenen, 2009). Self-efficacy, or the perceived ability to perform a behavior regardless of obstacles or challenges, is improved related to eating behaviors postoperatively (Batsis et al., 2009). The phenomenon of sagging skin postoperatively may cause dissatisfaction in body image, as reported by Bocchieri et al. (2002a), sometimes becoming more problematic in perception than the obesity. Regardless of this area of potential disturbances in body image, the literature overwhelmingly demonstrates increased self-concept after bariatric surgery.

Binge Eating Behavior. Binge eating or emotional eating is an eating disturbance that many obese patients struggle with before and after surgery. The incidence of pre-surgery clients diagnosed with binge eating ranges from around 40% (Adami, Gandolfo, Bauer, & Scopinaro, 1995; Kalarchian, Wilson, Brolin, & Bradley, 1998) to around 73% claiming to participate in grazing behavior (continuous eating or snacking) (Bocchieri, et al., 2002a). Due to the small nature of the postsurgical stomach and the stringent dietary guidelines the patient must follow, management of eating patterns is necessary.

While binge eating becomes harder to do postoperatively due to the small stomach pouch, bariatric surgery patients who do not change eating behaviors can find ways to graze on soft or liquid foods that pass through the stomach pouch quickly and can binge on high fat foods, in smaller amounts (Bocchieri, et al., 2002a, 2002b). Binge

eating has been associated with poorer weight loss results postoperatively (Toussi, et al., 2009).

Emotional eating, an urgency to eat in an attempt to mediate a mood when one is not physically hungry, is also of concern post-surgery. Bariatric surgery patients must learn not to eat when bored, upset, happy, sad, depressed, or for comfort or distraction. WLS patients need to implement new coping strategies to deal with these emotions to fully realize maximum weight loss and maintenance (Grimaldi & Van Etten, 2010).

In conclusion, psychosocial outcomes following WLS are positive, especially related to increased self-esteem, self-confidence, and assertiveness. Sagging skin or large panniculi can lead to worsening body image concepts. Weight loss surgery is not a cure for psychiatric disorders like depression or addiction; individuals need to be monitored as the disorders may become better or worse. Emotional eating and binge eating can continue to be problematic for WLS individuals; coping skills need to be taught and implemented in order to maximize weight loss.

Effects of Weight Loss Surgery on the Marriage and Sexual Functioning

There is a paucity of current studies investigating romantic relationships and sexual functioning following WLS. All studies reviewed only included married couples in the sample; there were no studies located that included non-married, partnered individuals, or same-sex couples. The literature examining these relationships after WLS shows conflicting results. Several researchers report improvements in intimate relationships and sexual functioning after WLS while some studies report deterioration of the relationship and increased sexual pressures following surgery. Increases in self-

esteem and physical energy can lead to improved sexual functioning, increased social activities, increased marital satisfaction, and decreased conflict with their partners (Goble, et al., 1986; Rand, et al., 1984; Rand, et al., 1982). While more marital discord was experienced preoperatively, 87% reported their marriages were good at three years postoperatively (n=54); however, it is interesting to note that 21% of participants in this study were divorced at three years postoperatively (Rand, et al., 1982). Rand et al. (1984) concluded that good marriages preoperatively stayed stable or improved postoperatively, while relationships with strife experienced a negative effect from surgery.

Increased sexual functioning was specifically reported by participants after WLS in two studies (Camps, Zervos, Goode, & Rosemurgy, 1996; Dziurowicz-Kozłowska, Lisik, Wierzbicki, & Kosieradzki, 2005). Ease of sexual relations after WLS was contributed primarily to the decrease in size of abdominal girth (Camps, et al., 1996), while increase in sexual satisfaction was reported by participants in as few as three months postoperatively (Dziurowicz-Kozłowska, et al., 2005).

Two studies demonstrated mixed findings related to sexual functioning and marital harmony. In a study by Kinzl, Traweger, Trefalt, and Biebl (2003), 59% of spouses reported an improvement in their marriages (n=109) while 45% reported an improvement in their sexual relationships. Almost half of these spouses (43%) viewed the surgery unfavorably preoperatively; postoperatively 77% viewed the procedure as positive. These spouses, however, reported an increase in negative behaviors, such as increased egoism, dominating behavior, and emotional instability, demonstrated by their

partners, but did state their partners had increased self-esteem, improved ability to handle stress, and a more active social life (Kinzl, et al., 2003). Another study by Kinzl, Trefalt, Fiala, Hotter, Biebl, and Aigner (2001) reported that the percentage of participants who were satisfied with their sexual relationship increased from 44% to 63% postoperatively (n=82), but 12% stated they enjoyed sex less postoperatively. While 20% of participants believed their partnership had changed positively after surgery, 10% reported a negative change in their relationship (Kinzl, et al., 2001).

The literature search produced three published studies that found a negative effect on relationships and sexual functioning after WLS (Hafner & Rogers, 1990; Marshall & Neill, 1977; Neill, et al., 1978). One retrospective interview study of 14 spousal pairs found that while 9 participants felt their marriages were unsatisfactory preoperatively, they felt fortunate to even be in a relationship (Neill, et al., 1978). Twelve participants reported a worsening of their marriage postoperatively, commonly citing jealousy and anxiety specifically related to the issues of dependency and control in the areas of social contacts, family workload, and employment (Neill, et al., 1978). The divorce rate at 36 months postoperatively was 21% (Neill, et al., 1978), the same rate as in the previously cited study that found increased marital satisfaction (Rand, et al., 1982). Neill et al. (1978) determined that obesity served as a stabilizing factor in these marriages; when the obesity was no longer an issue, an increase in discord ensued (Marshall & Neill, 1977; Neill, et al., 1978). Marshall and Neill (1977) discovered in their study of 14 WLS participants and spouses that increased feelings of rejection and threat led spouses to react negatively to their partners' increased attractiveness and self-esteem. Of these 14

spouses two noted they had only dated obese females prior to marriage, and interview statements revealed a sense of being unworthy or undeserving of a thin woman. During the postoperative period, two spouses discovered they were homosexual (Marshall & Neill, 1977). Postoperatively, the individual who lost weight was more sexually aggressive and demanding of sex. Two spouses became impotent in the three years postoperatively and attributed it to the increased demands placed on them by their partners (Marshall & Neill, 1977). Four couples described a decreasing interest in sex by the spouses after the partner lost weight (Marshall & Neill, 1977). Hafner and Rogers (1990) described an spousal elevated marital dissatisfaction twelve months after surgery (n=43), while the WLS participants (n=36) reported spouses being extra punitive as their assertiveness increased, which increased discord.

Recent publications highlighted these research studies on the impact of WLS on romantic relationships and concluded that surgery has both positive and negative effects on marriages (Applegate & Friedman, 2008; Bocchieri, et al., 2002b; Grimaldi & Van Etten, 2010). Some people experience better relations with their spouse, and the person's increased energy, elevated mood, increased ability to do activities, and improved self-concept made the marital relationship better (Applegate & Friedman, 2008; Bocchieri, et al., 2002a; Grimaldi & Van Etten, 2010). If the partner is mostly sedentary, resentment over this increased energy and new activities may occur, or the partner may feel neglected (Applegate & Friedman, 2008). Some individuals, as they gained assertiveness, autonomy, and confidence experienced tension in the marriage as the spouses began to feel threatened by this new person emerging (Bocchieri, et al., 2002a;

Grimaldi & Van Etten, 2010). Fear of abandonment and insecurity in the relationship is felt by spouses as their mates become more attractive to others after weight loss (Applegate & Friedman, 2008; Bocchieri, et al., 2002a; Grimaldi & Van Etten, 2010). Role and relationship changes are inevitable; time spent eating in front of the television must now change after surgery. The individual must spend time planning meals, exercising, and concentrating on him/herself; the spouse can feel a void and express resentment over the disruption of the family rituals (Grimaldi & Van Etten, 2010). The spouse may take on the role of food enforcer, commenting on every food choice, whether positive or negative, instead of being supportive (Applegate & Friedman, 2008).

While the effects of WLS on marriages and sexual functioning have been studied with mixed results, these studies were conducted in decades past; significant changes in the surgical technique, decreased recovery time, and changes in the social construct of marriage may have alternative effects on the marriage. This study helped fill this gap in the knowledge by identifying what the experience is like after WLS, not only for the person who had surgery, but also for the significant other who must deal with the lifestyle changes and rapid transformations. This study explored how the romantic dyad, inclusive of married couples, non-married but partnered individuals, and same-sex couples, is affected during this period of change after WLS.

Changes in Romantic Relationships in the Last Half-Century

Family relationships from a societal context are not static. In the past five decades, marriage rates have fallen while divorce rates have risen; defining characteristics of marriage have changed (Stevenson & Wolfers, 2007). During the

1960s and 1970s, the rise of the women's liberation movement, the sexual revolution, the removal of laws restricting marriage between races, the declaration of marriage as a fundamental right by the Supreme Court, and a sharp increase in the number of women in the work force all altered family life (Pagnini & Rindfuss, 1993; Stevenson & Wolfers, 2007). Today, marriage is often preceded by cohabitation, and the number of people with multiple marriages and divorces is high; by age 45, only seven percent of Americans have never married, and one-third of first marriages had ended with one-half of these divorcees have remarried (Stevenson & Wolfers, 2007). Cohabitation has become more socially acceptable in the United States. Although most currently cohabiting couples expect to marry, more couples are choosing to remain cohabiters instead of legalizing their relationship (Stevenson & Wolfers, 2007). Blended families, where each parent has a child or children by another partner, are more mainstream today; these blended families can be heterosexual or homosexual (Fuchsman, 2011). The traditional role of the female in the household, whose domestic responsibilities included cooking three meals a day, cleaning the house, childrearing, and supporting her husband as he works to earn the sole income, is obsolete. In 2010, more women were employed than men; while men are more involved in the running of the household and childcare, the bulk of this domestic work still falls on women (Fuchsman, 2011). The 2010 census reported an 80% rise in the number of homosexual couples who reported living together from the 2000 census, almost 650,000 couples, indicating increased acceptability of homosexuality (United States Census 2010, 2012).

The changes in the romantic relationship that have occurred over the past fifty years may affect how dyads cope with stress within the relationship. Health concerns, in particular, affect the dyad, and how the dyad copes with these health concerns can play a role in the maintenance or dissolution of the relationship.

Dyadic Coping with Health Concerns

Dyadic coping with stress is a topic that has attracted a growing number of theoretical and empirical studies since the 1990's (Bodenmann, Pihet, & Kayser, 2006; Revenson, Kayser, & Bodenmann, 2005). Major life stressors affect the individual, but also affect the lives of their romantic partners, children, friends, and others in their social network (Kayser, Watson, & Andrade, 2007). However, research, up until a decade ago, has focused on the coping efforts of the individual. In order to fully investigate how the romantic relationship changes or adapts with stressors, more studies need to be conducted using the dyad as the unit of analysis and on coping within the context of the romantic dyad.

Dyadic Coping

Two major theoretical approaches to dyadic coping have been identified; both are based on the transactional concept of stress and coping proposed by Lazarus and Folkman (1984), which is the most recognized and applied stress paradigm in theory and research (Bodenmann, et al., 2006). The first approach considers individual coping strategies and how these strategies are congruent or different with the partner's strategies; the level of congruence or dissonance directly related to the level of dyadic satisfaction and personal well-being (Bodenmann, et al., 2006). However, this approach considers

stress and coping as an individual phenomenon and measures these variables separately in both partners; dyadic analyses are made by comparing the stress and coping scores of each partner along with a congruence score (Bodenmann, et al., 2006).

The second approach views dyadic coping as a dyadic phenomenon in which stress signals from one individual in the dyad activate the coping reactions of both partners, expanding on the transactional view of stress and coping proposed by Lazarus and Folkman (1984) (Bodenmann, 1995, 2005; Bodenmann, et al., 2006). Bodenmann's Theory of Dyadic Coping follows this second approach and views dyadic coping as something altogether different from social support. There are three main differences between dyadic coping and social support: 1) dyadic coping offers "spousal" support, which is different than support that comes from others, such as neighbors, relatives, friends, etc. The romantic partner is often the most important source of support and has a different meaning to the individual than other forms of social support, because the romantic relationship has more meaning; 2) dyadic coping means a commitment between partners to ensure each individual's well-being and satisfaction, which in turn ensures the self's well-being and satisfaction and the smooth functioning of the couple as a whole; and 3) dyadic coping is more than support. Many other stress management behaviors may be employed during dyadic coping in order to deal with the stressors and resume normal functioning of the dyad (Bodenmann, et al., 2006).

Bodenmann's Theory of Dyadic Coping (2005) differentiates between positive and negative dyadic coping and problem- and emotion-focused dyadic coping. Positive forms of dyadic coping include supportive dyadic coping (helping with household chores,

offering empathy and understanding, communicating a belief in the partner's capabilities), common dyadic coping (joint problem solving, joint information seeking and sharing, sharing of feelings), and delegated dyadic coping (one partner is plainly and clearly asked by the other to do something, dividing tasks or offering support) (Bodenmann, 2005; Bodenmann, et al., 2006). Negative dyadic coping can take the guise of hostile dyadic coping (support comes with disparagement, mocking, sarcasm, open disinterest, or minimizing the severity of the stress), ambivalent dyadic coping (support is given unwillingly or with an attitude that the support should be unnecessary), or superficial dyadic coping (hypocritical, asking questions without really listening to answers, support that lacks empathy) (Bodenmann, 2005; Bodenmann, et al., 2006).

Empirical studies on dyadic coping show that positive dyadic coping is significantly associated with higher romantic satisfaction, decreased stress levels, and better individual well-being (Bodenmann, 1995, 1997, 2005; Bodenmann, et al., 2006). There are two ways that positive dyadic coping can increase relationship satisfaction: 1) by helping relieve the negative impact of stress (moderating function of dyadic coping) and 2) by strengthening the feeling of "we-ness," mutual intimacy and trust, and the knowledge that the relationship is helpful and supportive (Bodenmann, et al., 2006). Dyadic coping is viewed as a resource for coping with stress in addition to the individual's own arsenal of stress management and coping techniques.

Dyadic Coping with Health Concerns

By far, the majority of studies investigating dyadic coping with a health issue have been done with couples who are experience cancer, specifically breast cancer (Badr,

Carmack, Kashy, Cristofanilli, & Revenson, 2010; Hannum, Giese-Davis, Harding, & Hatfield, 1991; Kayser, 2005; Kayser, et al., 2007; Kuijer et al., 2000; Ptacek, Ptacek, & Dodge, 1994). In viewing how the partners' coping affected the women in the relationship, women who had a positive adjustment to breast cancer has been associated with the partners' use of problem-focused coping (Ptacek, et al., 1994); partners' use of active coping strategies also has been shown to aid the women's adjustment to the diagnosis (Kuijer, et al., 2000). Increased stress and distress among the women was associated with the use of wishful thinking by the partners (Ptacek, et al., 1994) and the giving up of external control (Hannum, et al., 1991).

When looking through the lens of how women's coping affects their partners, women who used optimism in their individual coping with breast cancer had partners who were less stressed (Hannum, et al., 1991). Ptacek et al. (1994) reported that the partners had increased relationship satisfaction and higher levels of mental health when the women were using less avoidance and more problem-focused coping when dealing with the illness. These studies indicate that both partners are affected by a breast cancer diagnosis; however these studies were conducted using the individual as the unit of analysis.

A study using methods of quantitative dyadic analysis investigated dyadic coping with metastatic breast cancer (N=191 couples) and concluded that the women experienced more cancer-related distress than their partners and that couples who used more positive common dyadic coping instead of negative dyadic coping had increased mutual adjustment to the diagnosis (Badr, et al., 2010). An interesting finding in this

study was that the breast cancer patients communicated their stress more often to the partners, whereas the partners verbalized their stress less, perhaps in an effort to shield the patient from having to deal with something else (Badr, et al., 2010); these findings are consistent with Coyne and Smith's (1991) findings in assessing female partners' coping with myocardial infarction in the male. When both partners share equally, it can increase positive dyadic coping; neglecting to share and deal with feelings can increase caregiver strain (Badr, et al., 2010).

Kayser, Watson, and Andrade (2007) found two patterns of relational coping in their qualitative study of 10 couples dealing with breast cancer. Mutual responsiveness was a method of coping used when the couple viewed the cancer as a disease affecting both partners, not just the female. The partners had open communication, discussed each other's stress and used problem- and emotion-focused coping strategies. This mutual responsiveness was felt to have increased not only the individual's resilience and strength but also to have enhanced the intimacy and closeness of the relationship. The second method of coping was called disengaged avoidance; the couples viewed the cancer as affecting each of them individually, not as a couple, or when other stressors in their lives were bigger than the cancer diagnosis. Coping was centered on dealing with practical tasks and not the emotional burden of either partner. No talking about the cancer occurred between the couple; this avoidance may have been effective in dealing with the stressors but can lead to negative relationship consequences and lower relationship satisfaction.

Feldman and Broussard (2006) used a dyadic coping perspective in assessing how men adjusted to the new breast cancer diagnosis of their female partners (n=71). Increased levels of hostile dyadic coping predicted poorer adjustment; these men reported that the negative coping style affected all areas of their lives, including sleep patterns, work productivity, sex, and their relationships with other family members. The high level of household disruption by this diagnosis coupled with increased negative coping by the male partner could lead to serious physical and emotional difficulties. These men indicated high levels of depression and decreased use of positive dyadic coping skills; they indicated feelings of helplessness and isolation. While these studies show the importance of using positive dyadic coping skills when dealing with cancer diagnoses, other health issues have also been studied using the dyadic coping perspective.

The dyadic coping perspective has been used in two qualitative studies that focus on other health issues besides cancer: spontaneous abortion in Jewish couples (Hamama-Raz, Hemmendinger, & Buchbinder, 2010) and coronary artery bypass grafting (CABG) (Whitsitt, 2009). Dyadic qualitative data can be collected in several methods; the most common methods are to interview the individuals in the couple separately, which may give greater exposure of the meaning attributed to the phenomenon by each member and its influence on the relationship (Hamama-Raz, et al., 2010), or to interview the couple together to get a joint picture of the experience and a shared narrative (Whitsitt, 2009). Both studies concluded what these different experiences were like for the couples involved. Neither study gave a clear picture of the dyadic coping processes used in dealing with these health issues. Hamama-Raz et al. (2010) used content analysis to

analyze the individual interviews, cluster meaning units, and create a narrative of coping generalizable to each couple; however the findings reported were individual themes with explanations of how the females and males coped differently with the miscarriage. No findings were reported in the context of the dyad. Whitsitt (2009) used Giorgi's descriptive phenomenological method to analyze his interviews with three couples; no mention of data saturation was made in the manuscript, and his findings focused on the experience and the stress of the CABG, but no mention of coping processes was made.

In conclusion, dyadic coping is a relatively new theoretical concept that is beginning to show how the couple as a unit deals with stressors, from everyday life hassles to catastrophic illnesses. The dyad as the unit of analysis is crucial in order to get the true experience of dyad instead of just the individual perspectives. Dyadic coping can be used as a theoretical framework to explore the experience of WLS on the couple, rather than the surgical individual.

This study will address the gap in knowledge concerning how modern couples experience WLS and the ensuing lifestyle changes. Current literature on WLS and romantic relationships shows mixed results and may not be applicable to today's WLS couple, as the studies were conducted in past decades. Bodenmann's Theory of Dyadic Coping (2005) has been used to assess how couples deal with stressors, including health-related stressors; therefore the use of this theoretical framework and the methods of data analysis enabled the researcher to explore the true experience of WLS from the dyadic perspective.

CHAPTER III

METHODOLOGY AND DESIGN

Introduction

This qualitative descriptive study attempts to understand the meaning of the lived experience of WLS for the romantic dyad from a stress and dyadic coping perspective. Past studies investigating the changes in the romantic relationship after WLS have left a gap in the knowledge due to several reasons: 1) the studies were conducted in past decades, when current surgical procedures, recovery time, and society's views on "marriage" have changed dramatically; 2) few studies involved the partner of the WLS individual; 3) previous studies only included married couples; and 4) no studies could be found that used the dyad as a unit of analysis. This study sought to expose how modern couples cope with the inherent lifestyle changes after WLS. Separate interviews of both the WLS individual and their partner were transcribed verbatim, read for meaning units and elicited themes to determine similar meaning for the WLS individual, the partner, and the romantic dyad.

This chapter presents the chosen methodology along with the rationale for choosing this method. The research design, procedures for participant selection, protection of human subjects, data collection, data analysis, and interpretation of data are presented. Issues of reliability and validity are discussed.

Methodology and Design

Having WLS and being involved in a romantic relationship is a unique experience, one that cannot be adequately described only through the use of quantitative methodologies. Previous research conducted on the romantic relationship after WLS has failed to capture the rich descriptions of the dyadic experience after WLS. Nursing, with its philosophy of caring and holistic approach to human experiences, has turned to qualitative research methods in order to more fully describe and understand the human experience of health and nursing. Many research questions simply cannot be answered by traditional empiric research methods. By using qualitative methods, nurses can ask new questions and provide rich descriptions of human experience in order to answer questions that cannot be fully answered by the scientific method.

Methodology

All qualitative methodologies have some element of description, interpretation, and explanation. While other qualitative methodologies have a specific goal of interpreting and explaining phenomena under investigation, qualitative descriptive studies are used when the researcher desires to describe a phenomenon, rather than explain it (Sandelowski, 2000). Qualitative description seeks to adhere strictly to the description of the phenomenon, or the experience of the participant, and “entails a kind of interpretation that is low-inference” (Sandelowski, 2000, p. 335). A low-inference approach to data interpretation helped the researcher describe a more natural and contextual depiction of the phenomenon being investigated (Sandelowski, 2000).

Qualitative descriptive studies can be considered the least theoretical of the qualitative approaches, in that researchers are the least restricted by pre-existing theoretical and philosophical commitments (Sandelowski, 2000, 2010). This does not mean that the researcher cannot be influenced by a theory or framework; qualitative descriptive researchers can begin a study by using a particular theory or framework that aids in the collecting and analyzing of data, but the researcher is not bound to retain the preselected framework if the data suggest otherwise (Sandelowski, 2000, 2010).

Naturalistic inquiry was one philosophical basis for this study. The researcher sought to study the phenomenon in its natural setting, in its own surroundings, where interactions with other phenomena abound, while attempting to achieve a deep understanding of the phenomenon as it occurs in the real world (Lincoln & Guba, 1985). In true naturalistic inquiry, the researcher uses techniques that allow the phenomenon to show itself as if it were not under study (Sandelowski, 2000).

Bodenmann's Theory of Dyadic Coping (Bodenmann, 2005) was selected as a theoretical framework by the researcher. The Theory of Dyadic Coping seeks to understand stress from a dyadic perspective and offers a different paradigm to consider how couples cope with stress. Since the study purpose was to examine the experience of WLS from a dyadic perspective, and the study assumes that WLS is a source of stress for the couple; this theoretical framework seemed a perfect fit to help explain the experiences of the couple after WLS.

According to Bodenmann's Theory of Dyadic Coping, a stressor causes a communication process to occur between the partners of the dyad (Bodenmann, 2005).

One partner's appraisal of a stressor is communicated to the other partner, who perceives, interprets, and decodes these signals and responds with some form of dyadic coping, which might involve either acting on or ignoring the stress communication (Bodenmann, 2005). Stress appraisals can be communicated either verbally or nonverbally. These stress appraisals can be initially perceived by either or both partners. Several factors, such as the cause of the stressor, responsibility for the stressor, and controllability of the stressor, play a role in how the dyad copes with the stressor (Bodenmann, 2005). Both partners make an effort to return to a state of homeostasis, either a level of pre-stressor functioning or personal/dyadic growth (Bodenmann, 2005).

Several assumptions underlie this theory of dyadic coping (Bodenmann, 2005). First, dyadic stress and coping must be conceptualized from a systems perspective; one cannot examine a partner's stress appraisals or coping efforts without considering the effects on the other partner and the marriage. Both partners are mutually influenced by each other's well-being; therefore, both partners should be motivated to help each other cope with stress. Second, dyadic coping is only one method used to deal with stressors. Individual coping and other support networks can and should be used for stress management. Third, dyadic coping is most often employed when individual efforts to deal with the stressor have failed. Fourth, dyadic coping involves both positive and negative forms. This theoretical description of dyadic coping was helpful to the researcher in formulating the interview questions and as an influence in data analysis.

The researcher acknowledges a struggle with the tension created by wanting to adhere to the tenets of naturalism and the reality that the Theory of Dyadic Coping may

explain how the dyads dealt with WLS. The researcher's interest in determining whether the dyad used any sort of dyadic coping to deal with the stressors caused by WLS outweighed the desire to adhere strictly to naturalism as the guiding philosophy. The rationale for using the Theory of Dyadic Coping as a framework for this study was the fact that few studies conducted on relationships after WLS used the dyad as a source for data collection, and none used the dyad as a method of data analysis. This theory deals with stress and coping by the dyad; WLS is an event that may be stressful for dyads. This theory can explain how the dyads coped with this health-related stressor and maintained homeostasis in the marital system. By having this framework influence the semi-structured interview and data analysis, the researcher hoped that a clear picture of what the WLS experience was like for the dyad and how the dyad coped with WLS would emerge.

Design

A qualitative descriptive design was used to answer the research question and achieve the purpose of this study. Straight descriptions of the phenomenon were desired, and the goal of the study was to understand the experience of the couple after WLS comprehensively and in everyday terms; therefore, qualitative description was the best design for this study (Sandelowski, 2000). In-depth, semi-structured interviews were conducted with each member of the dyad for a total of twenty interviews. Each interview lasted approximately thirty to sixty minutes and explored the intimate relationship between the partners of the dyad after WLS. All interviews were able to be transcribed accurately and were used in the data analysis.

Colaizzi's (1978) method of data analysis was used in the initial analysis of the data gleaned from the transcribed interviews. Colaizzi's seven steps of data analysis are:

1. Reading and rereading the participants' descriptions of the phenomenon to acquire a feeling for their experience and make sense of their account.
2. Extracting significant statements that pertain directly to the phenomenon.
3. Formulating meanings for these significant statements. The formulations must bring to light meanings hidden in the various contexts of the investigated phenomenon.
4. Categorizing the formulated meanings into thematic clusters that are common for all participants. Validating these clusters by going back to the original transcripts and confirming consistency between the researcher's interpretations and the original accounts.
5. Providing an exhaustive description of the phenomenon by integrating the findings.
6. Validating the findings by returning to participants to ask how the researcher's story matches with their own.
7. Incorporating any changes offered by the participants into the final description of the phenomenon (Colaizzi, 1978).

The initial data analysis plan was to analyze the data from the WLS individuals using Colaizzi's (1978) method and analyze the data from the partners' interviews using the same method to develop a story for each group of dyad members. Once the individual

data analyses were completed, a dyadic data analysis was performed using a method outlined by Eisikovits and Koren (2010).

Performing a secondary dyadic analysis was necessary in order to ensure the stories obtained from the individual analyses were accurate and trustworthy. The study was conceptualized from a dyadic perspective; therefore, a dyadic data analysis was needed in order to obtain the true dyadic experience after WLS. Dyadic analysis is more than the sum of the individual versions; it deepens and broadens the content and gives a true dyadic perspective of the phenomenon (Eisikovits & Koren, 2010). This dyadic analysis is a form of triangulation, which is a technical term originally used in surveying and navigation to describe a technique where two known points are used to plot the location of a third point (Begley, 1996; Knafl & Breitmayer, 1991). The use of triangulation in research is often related to confirming results and enhancing validity (Begley, 1996; Knafl & Breitmayer, 1991).

There are five types of triangulation commonly used in research: data, investigator, theoretical, methodological, and unit of analysis (Begley, 1996). Methodological triangulation may be called “mixed-methods” studies, as they use two or more methods to give a fuller and more accurate picture of the population studied. Data triangulation describes the use of multiple data sources, all with a similar focus, to obtain different views of the situation, with the goal of validation of the findings (Begley, 1996; Knafl & Breitmayer, 1991). Investigator triangulation involves two or more experienced researchers, each with differing areas of expertise examining the data, having prominent roles in the study, and having clear results in the study which show the differing expertise

of the different researchers; simply co-authoring a manuscript or working together on a study is not investigator triangulation (Begley, 1996). Theoretical triangulation is described as the use of all possible theoretical interpretations as the framework for a study with competing hypotheses developed from different theoretical backgrounds being tested against each other (Begley, 1996). Finally, unit of analysis triangulation uses two or more approaches to the analysis of the same set of data for the purposes of validation; quantitative data can be analyzed using two different families of statistical analysis, while qualitative data can be assessed for similar findings using differing analysis techniques (Begley, 1996). Knafl and Breitmayer (1991) regard this triangulation as more than the incorporation of more than one level of analysis; using the family as an example, the data can be analyzed at the level of each individual and at the level of the family. Eisikovits and Koren's (2010) method of dyadic analysis fits with Knafl and Breitmayer's definition of unit of analysis triangulation. By incorporating these two levels of analysis, this study takes into account both individual definitions of the experience after WLS as well as how these individual dyad members' responses come together to form a coherent dyadic coping style.

Role of the Researcher

Since the research question sought to describe the experience of the dyad after WLS, this qualitative descriptive study had phenomenological overtones. In keeping with the tradition of phenomenology, a bracketing interview was conducted with the researcher by a member of the doctoral faculty who was not on the dissertation committee. The faculty member asked the researcher the same overarching research

question that the participants were asked. The bracketing interview was audiorecorded, transcribed, and analyzed in the same manner as the participant interviews. The analysis of this bracketing interview revealed the researcher's beliefs that WLS would be a positive experience for the dyad and that the dyad would employ positive dyadic coping to deal with the stress created by WLS. The researcher showed some defensive emotion when asked to consider her reactions to partners who were not supportive of the WLS individual. The researcher realized her defensiveness and negative emotional reaction to this scenario. The researcher reviewed this bracketing interview before each participant interview, reminding herself of these reactions and putting them aside consciously during the participant interviews. Even though the researcher reviewed the bracketing interview before each interview, her personal experiences with WLS may have caused her to respond with excitement and enthusiasm in the interviews. This enthusiasm expressed by the researcher may have influenced the participants' responses so that they were not comfortable expressing negative thoughts or experiences due to social desirability.

Pilot Study

The researcher performed a pilot study with two dyads, one married and one cohabiting dyad, which had the experience of one member having WLS. These participants were interviewed jointly to elicit their experience. These interviews were audiorecorded and transcribed by the researcher, and a beginning data analysis using Colaizzi's (1978) method was performed. Based on the pilot study, the research question did not need revising; however, it was determined that joint interviews were not the best data collection technique to gather detailed descriptions. The women in the dyads had

WLS and were open and vocal about their experience. The male partners did very little speaking; in fact, one female answered all her partner's questions for him. In order to elicit the fullest response possible from the partners of the WLS individuals, the researcher opted to interview the members of the dyad separately. These pilot study interviews were not included in the data analysis.

Sample

A purposive sample of participants was selected by a snowballing sampling technique from professional and social contacts of the researcher. The researcher asked her various professional and social contacts to recruit potential participants who met the inclusion criteria. The researcher did not include any potential participants that she knew personally. Participants were intimate partners who live together in the same domicile and have lived together since before WLS. The surgical participants had either an open or laparoscopic Roux-en-Y gastric bypass procedure at least one year ago but no longer than seven years ago in order to enable the participants to fully recall the experience of coping with the lifestyle changes. Both partners were able to hear, speak and understand spoken English and agreed to be interviewed separately for approximately one hour each, being audiotaped during the interview. Recruitment occurred through social contacts. Participants who agreed to be interviewed about their experience received a \$25 Wal-Mart gift card as incentive for participating.

Recruitment and interviewing occurred until data saturation occurred, that is when consistencies were seen amongst interviews and recurrent patterns and themes emerged. Once this point was reached, two more interviews were conducted to ensure no new

themes emerged. The phenomenon was considered well-described when no new patterns or themes emerged. Ten couples were needed for saturation to occur.

Setting

This study was conducted in the Piedmont and Eastern regions of North Carolina through a snowballing sampling technique. Participants were asked where they would like the interviews to take place, with the concession that the location must be quiet and free of distractions, along with the expectation that the location provided privacy and confidentiality. Eight of the ten couples chose to be interviewed in their home. One couple chose to have the interview occur at their church on a weekday evening when no one else would be there. Another couple chose the researcher's work office as the setting for the couple's convenience.

Data Collection

In this study, data were collected through open-ended, in-depth, semi-structured interviews of both the WLS individual and the romantic partner at separate times. These interviews were consecutive, in order to prevent one partner from disclosing information revealed in one interview to the other partner. This disclosure might have affected how the second partner responds to the interview questions (Eisikovits & Koren, 2010). Every attempt was made to interview both members of the couple concurrently; however, scheduling conflicts within one dyad necessitated interviews on separate days. All other dyads were interviewed consecutively on the same day.

In the researcher's pilot study, two couples were interviewed with both partners present for the interview and responding to the questions. The researcher discovered that

by having both partners together, only one partner responded to the majority of the questions; in both cases, the more vocal participant was the female who had the WLS. The male partners were more reticent and required much probing to elicit their opinions or feelings of the experience. Eisikovits and Koren (2010) maintain that joint interviews can create a joint picture more easily than separate interviews, but that picture is often distorted towards the experience of one member of the couple, as both partners are not usually equally vocal when interviewed jointly. Joint interviews with both partners present as a follow-up interview to validate thematic structure was considered by the researcher; however, due to the confidential information provided by some participants, it was decided to not conduct joint interviews.

When interviewing the dyad separately, the researcher remembered that the partner is virtually present in the interview space. Separate interviews enabled the researcher to examine the overlaps and contrasts between the individual versions of each member of the dyad, which provided a more we-/I-oriented perspective (Eisikovits & Koren, 2010). Separate interviews allowed the researcher to capture the individual's subjective experience within the dyad without giving up either the dyadic experience or the individual experience (Eisikovits & Koren, 2010). Content was analyzed on both individual and dyadic levels.

The following open-ended question was used to begin the interviews: "What is your relationship like for you since you have had WLS?" or "What is your relationship like for you since your partner had WLS?" In order to avoid introducing the subject of stress and/or coping artificially, the researcher avoided using these terms in the interview.

If the participant did not mention stress or coping during his/her telling of the story, the researcher asked probing questions such as: “Has your relationship changed positively/negatively after WLS? In what ways?” “How have you overcome the issues of ...?” “Are there still issues within your relationship that you are still working on?” “Does your partner know about these issues?” The complete interview guide is available in Appendix A. A demographic form was also completed by each person; see Appendix B.

The primary instrument in this study was the researcher. Two audiorecorders (1 digital recorder and 1 minicassette recorder) were used to record the interviews in order to transcribe them verbatim for data analysis. The researcher collected field notes of responses, expressions, emotions, and the environment that may not have been adequately captured by the recorded interview and recorded these field notes in the digital audiorecorder immediately after each interview session. The researcher’s personal journal, part of the audit trail, was also audiorecorded and transcribed during the research process. The researcher attempted to contact all participants via telephone to validate thematic structure; three WLS individuals and three partners were reached and validated the researcher’s story.

Protection of Human Subjects

Prior to recruiting couples for this study, an application was made to the University of North Carolina at Greensboro Institutional Review Board, and approval to conduct this study was granted. Each individual was informed about the study, including the risks and benefits, before written informed consent was obtained; therefore, both

verbal and written consent was obtained. The consent form, approved by the Institutional Review Board, is located in Appendix C. The participants were informed that this study was conducted by the researcher in order to partially fulfill the requirements to obtain a PhD in Nursing. Information given to the couples emphasized the anonymity and confidentiality of all information; pseudonyms were used in the interview transcription, and all identifying information was removed to assure that persons or places could not be specifically identified from research documents and reports. Participants were asked to provide the researcher with an address and telephone number to validate the thematic structure and analysis of the data.

Each person was informed of their right to refuse participation in the study and was assured that their choice to participate would not affect any health care they may receive. Each person was informed of their right to pause the recording, stop at any time during the interview, and/or to withdraw from the study. No untoward effects were anticipated; however, each person was informed of their right to pause or stop the interview if any discomfort or distress occurred. The researcher was vigilant in observing emotions and behavior of the participants; the researcher would stop the interview and ask about their well-being, if they needed to stop/take a break/continue with the interview, if any tearing, crying, expressions of anger or anxiety, or other signs of distress were observed. No participant showed any signs of distress, and no participant chose to pause or stop the interview for any reason. The telephone numbers of local mental health groups and physicians were available to be given to any individual experiencing such

discomfort or distress that the interview was stopped. The participants were not informed of the researcher's own history with WLS until after the interviews were completed.

All transcripts, audiotapes, and digital recordings were held in confidence by the researcher. All study documents and files are stored on a password-protected laptop used solely for research, and written files are stored in a locked file drawer in the researcher's home office. The researcher possesses the only key to this locked drawer and has sole access to all study materials. An outside transcriptionist was used, and this person signed a confidentiality agreement for the University of North Carolina at Greensboro, and used pseudonyms assigned by the researcher in the transcription of the interviews.

Recruitment Procedure

Potential participants were recruited through a snowballing sampling technique through social and professional contacts via email or social networking sites. The researcher did not personally know any participants.

Data Analysis

Data analysis and data collection occurred simultaneously. Colaizzi's (1978) method of data analysis was used to analyze the individual transcripts. The researcher spent much time dwelling with the transcripts and in the interview data until the essence and the themes of WLS dyads were identified. This dwelling included listening to the recorded interviews several times, listening for voice inflections and comparing the researcher's field notes with the recordings. Spending this time with the data, or dwelling, allowed the researcher to be completely immersed in the data and required the researcher to be fully engaged in the analysis process (Speziale & Carpenter, 2007). The

researcher underwent a bracketing interview before the first participant interview; this bracketing interview was transcribed and reviewed by the researcher before every interview to help the researcher set aside her personal biases and beliefs about WLS. The researcher's feelings and thoughts were documented in a journal to assist with bracketing and the reflective process.

Significant phrases and statements were extracted from the transcripts that formed the complete meaning of the experience of the dyad after WLS, according to Colaizzi (1978). These extracted statements were collected together in one word processing document for convenience and to enable the researcher to gain a new perspective on the data. Each transcript was analyzed to identify statements that tell each participant's story as completely as possible.

Formulated meanings for the extracted statements were developed that describe the experience of the dyad after WLS. These formulated meanings were general restatements or meanings for each significant statement identified in the analysis. Analytical coding, or developing meaning units, was done by the researcher, assisted by a member of the dissertation committee, to formulate meanings. This coding was done mainly by reflection; reflecting on the words of the participants and on their inflections and other observations noted in the researcher's field notes.

These formulated meanings were organized into clusters of themes, which were then collapsed into themes. The researcher consulted a member of the dissertation committee with expertise in Colaizzi's (1978) method for validation of the themes and to ensure the process was described clearly and accurately. The researcher additionally

discussed in the text how decisions were made related to the clusters of meaning units around the themes. The themes were validated by returning to the participants in a telephone interview; all participants contacted stated the themes and exhaustive description provided by the researcher matched their stories.

Dyadic Analysis

The interpretation of transcripts was done in three parts: 1) the WLS individual, 2) the partner, and 3) the dyad as the unit of analysis. The transcripts of each individual occurred by the Colaizzi method outlined above. The dyadic analysis was performed using the method outlined below by Eisikovits and Koren (2010).

The first step in this dyadic analysis is to be mindful of the context of the dyad's joint life when analyzing the individual's transcripts. This mindfulness allowed the researcher to see the similarities and differences between the two experiences, to capture the dynamics between "I-ness" and "we-ness" (Eisikovits & Koren, 2010). The researcher distinguished between what belongs to the individual perspective and what is unique to the dyadic experience.

Using a word processing program the researcher highlighted significant statements, sentences, and quotes that provided an understanding of how the participants experienced the phenomenon and developed meaning units from these significant statements. By assessing contrasts and overlaps between the individual versions, theme examination from the dyadic perspective occurred (Eisikovits & Koren, 2010). This dyadic view can lead the researcher to possibly reconstruct various versions of the

existing themes and may lead to unique subthemes. The dyadic version is more than the sum of the two individual versions.

Overlaps and contrasts between the individual stories can occur on two levels: descriptive and interpretive. In the descriptive level, the researcher examines the transcripts at face value, looking for similarities or differences between the partners' stories. Next, the researcher accounts for the context of the conversations and interprets what is actually being said in the interviews. The individual stories may appear very similar but have very different interpretive meanings or connotations, and vice versa. Overlap does not automatically mean the couple experience things the same, nor does contrast mean that the individuals are experiencing the phenomenon separately. Both the open and hidden realities of the dyad point to whether the couple experiences things together or separately and are aware or unaware of their "we-ness" (Eisikovits & Koren, 2010). Contrasts and overlaps can teach us about the individual viewpoint but can also be considered as the structure of the dyadic analysis narrative (Eisikovits & Koren, 2010).

The resulting dyadic analysis yielded no new themes; the individual themes accurately told the stories of the experience of the intimate dyad after WLS. These themes were verified with select participants, who agreed that their stories were represented accurately by the researcher's interpretation.

Validity and Reliability

Research must be valid and reliable. The ability to describe and demonstrate an audit trail of decisions made during the data collection and analysis process, as well as

the researcher's feelings, emotions, and reflections, aided in promoting study credibility.

A variety of techniques were used to enhance validity and reliability.

Validity refers to whether one has investigated what one set out to investigate. Therefore, the interview must set out to investigate the experiences of those who are interviewed. The interview questions were reviewed by the dissertation committee and approved prior to interviews taking place. Revisiting the bracketing interview put prejudices and preconceptions in the forefront of the researcher's mind prior to every interview, so that leading the participants based on the researcher's beliefs was avoided. Pollio et al. (1997) state that the validity of a study is based on methodological issues (are the methods used rigorous and appropriate to the questions) and experiential issues (are the findings plausible and enlightening). Validity is more determined by whether enough convincing data has been brought forth to validate the descriptions and themes (Thomas & Pollio, 2002).

Reliability typically describes the consistency of research findings; however, since no two interviews will ever be the same, reliability takes a different view in qualitative research. One, reliability can describe whether the reader can understand the researcher's point of view (Thomas & Pollio, 2002). Second, reliability also refers to whether the same thematic structure would occur if a new study was done on the same phenomenon. While the researcher is charged with identifying general structures and processes of experience despite obvious differences in the individual interviews, the overall aim of replication can be said to be to extend and not duplicate the themes described in the original study (Thomas & Pollio, 2002). Bringing about new viewpoints

of the phenomenon under investigation is another test of study reliability (Thomas & Pollio, 2002).

An audit trail, consisting of field notes, decisions about themes, discussions of overlaps and contrasts in the dyadic analysis, and the researcher's feelings and thoughts were kept during the research study. All of the described items were kept in the researcher's private laptop in word processing documents. The audit trail was kept up to date and was available to the dissertation committee at any time.

Delimitations

The following delimitations were imposed on the study to ensure the research questions were answered:

1. Individuals who have had open or laparoscopic Roux-en-Y gastric bypass at least one year ago and no more than seven years ago. This interval is necessary in order to ensure the elicited experiences can describe the continuum of transformation and to elicit all possible experiences of stress and coping postoperatively. This limitation of participants to individuals who had Roux-en-Y gastric bypass contributed to a more homogenous sample.
2. These individuals must have resided together, considered themselves in a monogamous romantic relationship before the surgery and continued to be in such a relationship with the same partner at the time of the study.
3. The surgery individuals must have been at least 18 years of age, in order to elicit the experiences of adults in romantic relationships.
4. The couples must have spoken and understood spoken English.

5. The couples must have been willing to be interviewed separately, but consecutively, at the time and place of their choosing, and the interviews be audiorecorded. This separate interviewing allowed the voice of the individual to be expressed freely without considering the voice of the partner and allowed for analysis of overlaps and contrasts, the essential units of dyadic analysis.

Conclusion

This study provides a unique look at the experience of WLS on the individual, their partner, and the dyad as a whole. Qualitative description was used as the study design, while Colaizzi's (1978) data analysis method was used as the initial data interpretation method. The Eisikovits and Koran (2010) method of dyadic analysis was used secondly to interpret the meaning of WLS for the dyad. Bodenmann's Theory of Dyadic Coping (2005) was used to guide the data collection and analysis to determine how the dyads cope with the possible stress after WLS. The WLS individual and the partner were interviewed separately but consecutively in all but one dyad in order to avoid the participants discussing the interview questions and possibly biasing the responses of the second individual interviewed. All reasonable methods to ensure protection of human subjects were taken. Reliability and validity of the study were ensured by various methods, one of which is an audit trail, kept by the researcher concerning all decisions made in the data collection and analysis process. Participants were ensured of confidentiality; pseudonyms were used in all transcripts. This study serves to help fill a major gap in the literature regarding the experience of the romantic couple after WLS by using an innovative method of dyadic analysis.

CHAPTER IV

STUDY FINDINGS

This chapter describes the sample and findings of the study. Findings are presented in accordance with Colaizzi's (1978) phenomenologic methodology and include extracted significant statements, their formulated meanings, themes that were common to all participants, and an exhaustive description of the dyadic experience of having WLS. The dyadic analysis using the method outlined by Eisikovits and Koren (2010) is presented. All words in quotation marks are taken directly from the transcripts of the participants' interviews.

Sample Characteristics

The sample consisted of ten heterosexual couples who were all legally married. Upon initial contact with the researcher, volunteer participants verbalized meeting the study inclusion criteria: both members of the dyad were at least 18 years old; the couple resided together in a domicile; one member of each dyad had undergone WLS at least one year ago and no longer than seven years prior to the interview; the dyad spoke and understood spoken English and agreed to be interviewed and audiorecorded. The WLS individuals consisted of three males and seven females. The couples lived in the southern Piedmont and Eastern regions of North Carolina. There were nine Caucasian dyads and one African American dyad. Their ages ranged from 36 years to 59 years old with the mean equaling 47 years. The mean number of years the dyads had lived together was

21.1 years (10-30 years). To ensure confidentiality, participants were given pseudonyms in alphabetical order of their interviews with the researcher; both members of the couple were given pseudonyms beginning with the same letter of the alphabet in order to more easily identify the partner of the WLS individual. A summary of the demographic data appears below in Table 1.

Table 1

Participant Demographics

Participant Pseudonym	Age	Identified Race	Yrs Dyad Has Lived Together	Yrs Since WLS
Adam	42	White	22	3
Anna	43	White		
Barbara	51	White	30	2
Bill	50	White		
Christine	51	White	29	1
Charlie	52	White		
Dale	43	White	13	1
Debbie	43	White		
Elvira	37	White	17	3
Eustice	43	White		
Fiona	42	White	22	1
Frank	49	White		
George	52	White	23	2
Glenda	55	White		
Helen	37	White	10	3
Henry	36	White		
Irene	54	White	30	7
Ira	59	White		
Jane	53	African American	15	3
John	48	African American		

Vignettes

Brief vignettes about the participant dyads are included to provide a short descriptive view of who the participants were as individuals and dyads. These vignettes provide a snapshot of who the dyads are as the researcher has come to know them.

Adam and Anna

Adam and Anna have been in a relationship “since 6th grade.” Adam had WLS three years ago. Anna is a nurse and seemed to feel comfortable with the researcher and the interview from the beginning. They were interviewed consecutively at their kitchen table in their home; while one member was being interviewed, the other member of the couple was upstairs out of hearing distance. Both Adam and Anna were polite, and both showed interest in the interview. This dyad has three daughters, all teenagers, and is devoted to their family life, as evidenced by their interviews. Adam was reticent to divulge much detail during the interview and was content to state his marriage was unchanged since the surgery, since they were a strong Christian couple prior to the surgery. Adam states, “We have just been together for so long that we know each other better than we know ourselves,” and “There is no way that we could do anything without each other.” He gained most of his weight after securing a sedentary office job but states Anna never made him feel bad about himself because of his weight and he always felt loved by her. He had diabetes that was under control with medication, but he felt that was his only significant health problem. His surgery was “smooth sailing” and states no marital or sexual issues have arisen since his surgery. He is the main cook for the family, since he arrives home in the evenings before his wife; Adam states that his cooking

routine has not changed since the surgery. He just made himself something different when he was on a restricted diet, but now that he is so far out from his surgery, he eats whatever he makes for his family, just smaller amounts.

Anna tells somewhat of a different story, one that focuses more on how the family's relationship with food has changed. Adam and Anna used to enjoy taking cruises for vacation, mainly for the food, but she wonders now what they would do on a cruise, since food cannot be the focus anymore. Anna states how the family cannot eat out at buffets anymore, since Adam typically gets sick afterwards. Restaurants pose problems as well; while the family of five can split a couple of entrees and save money, she feels guilty at times because she does not think Adam can "enjoy some of it as much as he might have liked." She comments on how much Adam has changed, how much more energy he has and how much more time he spends with their daughters interacting, whereas before he spent "a lot of time on the couch, a lot of time just not feeling good." However, she does comment on the fact that surgery does not fix the emotional reasons for overeating; "sometimes I get real concerned because the mind is not fixed with gastric bypass." Anna thinks that Adam has resorted to some of his old habits, like emotional eating, eating at night, and eating salty and sweet things to satisfy cravings. She notes that he has gained some weight back, although she does not know how much, just that some of his pants are getting tight again. When questioned by the researcher about talking to Adam about her concerns with his eating habits, she stated that she "was not a very good communicator, honestly, so I just do not want to hurt anybody's feelings, so I would rather just not say anything." She feels that voicing her concerns, whether it was

her concerns and fears about the surgery preoperatively, or her concerns now about his eating habits, would constitute nagging.

Barbara and Bill

Barbara and Bill are entering middle age. Barbara had WLS two years ago. They have one child still at home and one child married; they are expecting their first grandchild in a few months. They were interviewed consecutively in their living room; the other partner was out of hearing distance while one was being interviewed. Barbara was very open about her feelings and expectations after surgery; Bill was more closed and reluctant to discuss anything of a personal or private nature.

Barbara spent a great deal of time discussing things that “got on [her] nerves” after the surgery. In the first few months postoperatively, her family made her mad because she would prepare a meal for them that she could not eat and never received any gratitude or appreciation for her effort. She believes she may “have transferred [her] addiction to eat” onto her family; she described making cakes, pies, and things she could not eat and how she would get mad at her husband when he would not eat them. When she would communicate her feelings with Bill, his reply was, “Well, I told you not to have this surgery done. You don’t have anybody to blame but yourself.” Barbara states she knows that Bill still loves her, but he is human too, so when she would “fuss at him and get upset,” he would reply with “little smart-aleck comments.” Now, Barbara feels judged and watched by others; she feels that her husband and the general public are watching her to see how much she eats and what foods she is eating, as if they are

waiting for her to gain weight. But overall, Barbara feels they have settled into their new lifestyle now and have a “normal relationship.”

Bill spoke more of accommodating Barbara’s needs, focusing on her physical needs more than emotional ones. He felt proud that he always provided for her and made sure the pantry was stocked with her protein shakes and bars. He spoke of how they shared baked potatoes and entrees at restaurants. Bill also stated that they eat much healthier now and have incorporated much more fish and other lean meats into their diet. Bill denied any problems in their relationship or sexual relationship; Barbara indicated sex was much more painful now after the weight loss due to the loss of tissue in her perineal area. Barbara and Bill both commented on her increased energy and stamina and excitement about buying regular clothes “off the rack”.

Christine and Charlie

Charlie and Christine are also entering middle age. One year ago, Christine had WLS. They have children and grandchildren; they also have children remaining in the home. They were interviewed consecutively in their living room out of hearing distance of the other partner. Christine’s interview resonates with shame and guilt over gaining so much weight, becoming diabetic, and starting to lose kidney function. She expressed perceptions of lack of intimacy between her and Charlie when she was heavy; she felt like he would walk in front of her, not with her, and rarely showed signs of affection in public. She perceives this has changed after the surgery and discusses how Charlie now holds her hand and shows affection. Christine felt the weight put a strain on their marriage; she slept in a different bed due to her sleep apnea and snoring. She still sleeps

in a separate bed, just from habit now, and not due to keeping Charlie awake with her snoring. She kept her weight secret from Charlie; in fact, Charlie stated that “she pulled the wool over his eyes” because he never knew she weighed over 250 lbs. Christine and Charlie did not communicate much about the surgery; she took a friend instead of Charlie to her surgery appointment because she was ashamed of how much she weighed. Christine does feel the surgery is the best thing that she could have ever done. She states they had a good marriage when she was heavy, and it is better now that she is not ashamed of her weight.

Charlie denies any negative issues within their relationship due to the surgery and states that he is glad she had the surgery and is so much healthier now. He states several times that he wishes she would have had surgery when she was younger so her skin would have “gone back” better. He also expressed how they have “his” and “hers” snacks. It does not bother him to “pop the top” on a soda just because she cannot drink it. He feels she had the surgery not only for her health, but for him as well, and he is appreciative of her sacrifice.

Dale and Debbie

Dale and Debbie were interviewed in the researcher’s office at a university in North Carolina. They were interviewed consecutively. Dale had a meeting on another floor of the building so he was out of hearing range during Debbie’s interview; Debbie waited in a conference room down the hall during Dale’s interview, so she was out of hearing range also. They have been together for fourteen years and have young children remaining in the home. Dale had the surgery eighteen months ago and has lost

approximately 180 pounds. He did not have any major health issues besides joint pain related to his obesity, but felt like health problems were inevitable. Dale expressed the regret that he did not have the surgery sooner; he has experienced no complications and is so grateful to have the excess weight gone. He is a registered nurse who previously worked in hospital administration; with the weight loss and subsequent increase in self-esteem, he now is a nursing instructor and recently graduated with his Master's degree in Nursing Science. Dale feels that he would have never been able to become an instructor, both physically and emotionally, had he not had WLS. He feels much healthier and is much more active with his young children. Dale wonders if his wife, Debbie, would be interested in having the surgery, but stated that he was not sure Debbie could handle the postoperative restrictions. Debbie did not mention the possibility of having WLS during the interview. The largest problem in the day-to-day running of the household after Dale's WLS was

trying to cook a meal for everybody in the house, because there were some things that would make him sick, he couldn't eat....That was probably the biggest thing, just with two kids trying to cook something everybody could eat or either I'd end up having to fix him one thing and everybody else eating something else.

Debbie and Dale both stated their lives are so busy with work, his education, and the kids' activities that there has not been a significant change in their relationship after the WLS.

Elvira and Eustice

Elvira and Eustice were interviewed at their church; they have two sons, ages ten and eight, at home. Elvira felt more comfortable being interviewed at their church, in a

quiet environment away from their children. Elvira and Eustice have been in a relationship for eighteen years, and Elvira had WLS three years ago. Elvira was very open in her interview and discussed at length her emotional addiction to food and childhood events that were a perceived precursor to this food addiction. Both participants relayed how WLS is “just a tool” for weight loss; in order to be successful one must deal with the reasons why one overeats and the emotional eating that often occurs. Both Elvira and Eustice discussed how their marriage is much stronger now after her WLS; their lines of communication are much more open now that she has dealt with her “demons.” Elvira is much more active and energetic. She is trying new activities and commented how even her children, as young as they are, notice her increased activity level and her willingness to do new things with them. Eustice stated that the only minor negative aspect related to the WLS is trying to find something she can eat when they eat out at restaurants. They tend to eat “on the run” frequently due to the kids’ activities, and finding something appropriate for Elvira to eat can be frustrating for all. They have learned to plan ahead and to pack suitable food. Overall, both participants felt their marriage was better as a result of her WLS. Elvira stated, “I’m present”, whereas before she felt she was “just going through the motions.”

Fiona and Frank

Fiona and Frank were interviewed in their home in their living room separately with the other partner out of hearing range. They have been married for twenty-two years and have two teenage children in the home. Fiona had WLS fifteen months prior to the interview. Both Fiona and Frank were reserved and seemed reluctant to talk in depth

about their relationship. Fiona stated that she believes their marriage had not changed as a result of WLS; she felt more attractive and romantic towards her husband as a result of her weight loss, but no other changes were significant in her perception of their relationship. Frank stated he felt their sexual relationship had improved since her weight loss and they were more active as a family. They both discussed how they eat healthier as a family. She expressed some guilt over focusing on herself immediately after the surgery instead of on her family but felt like her healthy behaviors transferred onto her children and husband, making her temporary focus change worthwhile. Fiona felt supported by her family throughout her postoperative period and now she has increased energy.

George and Glenda

George and Glenda are midlife and have been married for twenty-three years. They are empty nesters. They were interviewed in their living room; Glenda was in a back room during George's interview, while George was outside during Glenda's interview. George often speaks to WLS support groups and at functions about WLS; he is very proud of his role as "the poster child" for what to do after WLS. While a specific amount of weight lost was not mentioned, in the two years since his WLS, George has won his age class in several running and bike races. He is now training for a triathlon. He stated their eating habits and activities have changed, but the overall emotional tone of their marriage has not changed. George is focused on adhering to his postoperative regimen and states that WLS individuals need to be self-centered in order to gain all the benefits the surgery has to offer. He states that others in a relationship with WLS

individuals need to be prepared for change, as the WLS individual is going through “a lot of changes themselves.” Partners should not “encroach on their [WLS individuals’] ability or time or need to do” activities to aid their weight loss. Glenda agrees with George on this matter. She understands his need to exercise and to run or bike in races, but sometimes wishes he would not race every weekend. She knows her husband and knows his personality is to do everything “110 %” so she is willing to sacrifice some time with him in order for him to be happy. Both George and Glenda deny any complications or issues in their marriage or sexual functioning and state that George’s weight loss has led to more confidence, more energy, and more security in his self-concept.

Helen and Henry

Helen and Henry are in their thirties with a young child at home. The interviews took place at Helen’s mother’s home in eastern North Carolina; her mother watched the child while Helen’s interview took place. Helen was interviewed first; Henry did not arrive until Helen’s interview was finished. Helen then left her mother’s house with their child, so Henry was interviewed without any chance of Helen overhearing. Helen was outgoing and open about her experience; Henry was more closed and reluctant to talk. Helen has no regrets about her WLS, which was three years ago, although she thinks she is gaining back some weight. Regaining her weight frightens Helen a great deal. She spoke at length about trying to eat healthier and wished she could go back to the liquid postoperative diet she had immediately after the surgery, because her life was simpler. “I don’t have to worry about it. It doesn’t matter. It’s going to take two minutes to suck this drink down, and I got the rest of my day.” She discussed how the surgery did not fix

the mind and how she is beginning to constantly focus on food again. Helen and Henry are committed to maintaining Helen's weight loss and eating healthier to help Helen feel in control of her weight.

Both Helen and Henry claim their marriage has improved after her WLS. They spoke of how they are more active and do more outdoors activities, instead of lying on the couch watching television. Helen likes that she is able to do more with her daughter. Helen feels supported by Henry and denies any negative effects to their marriage from the WLS. Henry, in turn, feels supported by Helen and does not feel denied or neglected in any way due to her lifestyle changes.

Irene and Ira

Irene and Ira were forthcoming in their interviews. This couple was the only couple interviewed at different times due to Irene's schedule. Ira was interviewed in his living room; Irene was out of town. Irene was interviewed the next day at a restaurant in a different town from where they live; she had not been home or in contact with Ira since his interview. Irene's WLS was seven years ago. Ira was the first partner to express remorse over Irene's WLS; he believes that their life has changed dramatically, and they are unable to celebrate with food and alcohol as they were accustomed. Irene acknowledged this change in their lifestyle, but remarks that they have withstood multiple life-changing events over the past fifteen years and attributes the change in their marriage more to these events than to the WLS. As Irene stated, "What's 'celebrate like we used to' got to do with it? I can celebrate. I'm still alive. I didn't throw a clot. I haven't died, I mean, you know." Ira expressed amazement at his inability to truly see

Irene at her heaviest; he stated several times with incredulity how big her “souvenir” pants were. “How can you be oblivious to somebody who was twice as big as they are now?”

Secrecy was an issue with this couple. Irene admitted keeping details about the surgery a secret from Ira because she was ashamed at her weight and at needing the surgery. He discussed how unprepared he was for Irene’s surgery; many of Ira’s issues with Irene’s WLS may have been avoided with adequate preoperative preparation. Ira did not know what to expect postoperatively and was fearful of any minor health problem Irene may have had. Irene thinks that she introduced her new lifestyle appropriately with her family and felt they did not “know the difference.”

Jane and John

Jane and John were interviewed in their living room in their home. They are in their fifties and have no children at home; however a young grandchild was at the home during the interview. They have lived together for fifteen years. Jane had WLS three years ago. Jane and John both expressed their love of travel; Jane’s excess weight did not affect their amount of travel before the surgery, but they are able to enjoy travel more now that she has less weight and increased energy. Jane had the surgery for health reasons; she had hypertension and diabetes prior to WLS. She stated, “I’ve always looked at myself as being a pretty woman and a sexy woman, even when I was bigger.” Both she and John enjoy her new body; Jane feels sexier now and feels John appreciates her new size, even though he was strongly opposed to the surgery. John stated how her weight never bothered him; he found Jane sexy and attractive before the surgery. Fear

was his primary motivating factor in discouraging the surgery – fear of the unknown, of complications, of Jane’s possible death. Both participants discussed how their faith and prayer led them to pursue the surgery eventually and how their faith and prayer have enabled them to cope with the minor lifestyle changes after surgery. They deny any negative effects to their marriage and state being more romantic with each other as the main positive effect after WLS.

Summary of Interviews

The ten dyads interviewed for this study share the experience of one member of the couple having WLS within the past seven years, yet they are all unique. Nine of the couples expressed very minor or no negative aftereffects on their relationship after WLS; one partner expressed anger and remorse over the perceived changes in his relationship, yet his partner attributed these changes to other life events and not the WLS. All the dyads were embedded in their partnerships, and most told their individual story with a great deal of “we-ness”, indicating a true dyadic partnership. All of the couples developed an interest in the researcher, not only as a researcher and student, but also as a WLS individual.

The researcher was comfortable entering the homes of the participants and talking with them. Most of the WLS individuals showed no obvious discomfort at being interviewed and shared their experiences openly, while some of the partners expressed some hesitation and reluctance. These participants shared their stories, and adequate data was collected in these interviews to answer the research question.

Study Findings

First, Colaizzi's (1978) descriptive, phenomenological method was chosen to guide the analysis of the data collected in the individual interviews in this study. Dyadic analysis was then performed by the method outlined by Eisikovits and Koren (2010). First, each of the participant's digital audio recordings were listened to and transcribed into a written text by a trained transcriptionist. The researcher then listened to the digital recordings while verifying word-for-word accuracy in the typed transcripts. The transcripts were then read line-by-line by the researcher multiple times. Significant participant statements and phrases pertaining to the experience of having WLS were identified in the transcripts, and meaning units, or codes, were formulated that accurately reflected each statement or phrase. The significant statements were reviewed to ensure that the formulated meaning unit accurately reflected the intent and context of the statement. There were originally thirty-three meaning units; three were dissolved when the statements were thought to actually represent a different meaning unit, and no other significant statements truly reflected these three meaning units. The remaining thirty meaning units were organized into six broad categories, which were then reduced into four themes. The themes were reviewed and compared to the meaning units again, with both a fellow doctoral student and a member of the dissertation committee with expertise in qualitative analysis, to ensure all significant content in the transcripts was reflected by meaning units and themes. An exhaustive description of the phenomenon was developed from the results of this data analysis. This description was shared via telephone interview with six participants in order to validate the researcher's interpretation of their stories.

The researcher attempted to contact all participants for validation of the themes and resulting story. Three WLS participants and three partners were reached by telephone, and the descriptions were read to them. Both the WLS individuals and the partners agreed with the exhaustive descriptions. “That sounds exactly like what we’ve gone through,” said one partner.

Originally, the intent of this first step in the data analysis was to analyze the WLS individuals’ transcripts separately from those of their partners. However, upon coding, it was determined that the transcripts of both sets of participants contained the same meaning units. There were no meaning units that contained solely significant statements from the WLS individuals or their partners. In fact, some of the transcripts revealed almost word-for-word descriptions by both the WLS individual and their partner. For this reason, it was determined that the set of transcripts should be analyzed as a whole and not separately by participant (WLS individual or partner).

Meaning Units

Once meaning units were identified using line-by-line analysis of the transcripts, they were extracted from the transcript and placed in the researcher-designed document for ease of analysis. There were thirty meaning units; multiple statements were categorized in more than one meaning unit. Some examples of meaning units with corresponding participant statements are as follows:

Surgery is a tool

1. ...the emotional eating, the eating at night, that has resurfaced, so in that part I'm kind of disappointed that – that didn't completely – it can't cure the mind, it's still going to be there.
2. Ultimately, the weight loss surgery is just a tool, it's not the solution. It's just a tool. She still had to find that motivation from within to realize, I've got a problem with eating, and I've got to stop.

Sex is worse

1. Um, he kind of thought that I would be more interested in sex, but that ain't the case either (laughs). In fact – in fact, my – I want it less now than I did. But when I started losing so much weight and getting so much smaller, it was painful. I don't know if it's because there's nothing down there anymore but bone. Before, you know, it – I guess I had enough padding down there. But, you know, you just – it – it just – it – it hurts sometimes. Seriously, you've got all this hanging skin, and even in your vagina area - is a lot of hanging skin, and there's no – there's no fat down there anymore, and it does hurt, I'll be honest with you. It's painful.

Marriage unchanged

1. Um, it really hasn't really changed a whole – you know, a whole lot. Um, we've always been, you know, very close, um, very honest with each other. Um, I – I think we have just a really good relationship, a very close

relationship. I mean, we're – we're both Christians, so it's a Christian-based relationship.

2. I don't think there's a lot of difference in our marriage since surgery. I've always had a very busy life. She's always had a very busy life, (laughs) so, you know it's been much the same, I'd say. We have two children, so they keep us very busy between my work, her work, my school, and we are active in our church, so there is always something to do.

Change in relationship with food

1. Yeah. Actually, initially, yes. And – and I think about we used to – before children, we used to go on cruises occasionally. And, you know, that is a big eating fest, and I've thought about it – since then, thought, Well, would we really enjoy something like that so much? Because neither one of us are very physically, um, active. We don't do sports. It's not like we would go on a cruise and decide to go scuba diving. Or, you know, rock climbing. We might do a little bit of it, but our fun was, you know, um, eating. Adam likes to play the slots. But, yeah, I guess because you don't enjoy it as much because you're afraid. Um, when we would go out to a buffet, he loved and still tried to eat some of the stuff at the buffet, but before we left he was in the bathroom throwing up. So it's hard to enjoy that sort of thing. We finally just gave up the buffets and said that was the end of that .
2. We ate. Growing up, I mean – and this is my family growing up, and then now it's like, you know, as soon as somebody has a birthday it's like, "Where

are we going to dinner?” “Where are we gonna go? Where are we gonna go to dinner?” And my birthday this year, what I really wanted to do, which we ended up not really being able to do much of anything, but what I wanted to do was to get a kayak for the day. That’s what I wanted to do. You know, I don’t want to focus it on the food. Um, we – I take my daughter to the beach. And we go to the pool. We go to the park, um, we walk the neighborhood.

The following table shows the frequency of each meaning unit in total, as well as a breakdown of frequencies of each meaning unit by WLS individual and partner. No meaning units were solely expressed by either the WLS individual or their partner. The partners shared many of the same experiences as the WLS individual, and the distribution of frequencies of each meaning unit, for the most part, was equal between the WLS individuals and partners.

Table 2

Frequency of Meaning Units in Transcripts

Meaning Unit	Total Frequency within Transcripts (# times appeared)	Frequency of Meaning Unit by WLS Individuals	Frequency of Meaning Unit by Partners
Marriage changed	23	13	10
Marriage unchanged	45	18	27
Sex better	17	13	4
Sex unchanged	7	3	4
Sex worse	8	7	1
Accommodating partner	143	84	59
Life too busy	23	12	11
More active	61	34	27
More confident	34	18	16
Improved body image	20	12	8

Positive experience	37	19	18
Concern with others' feelings	5	4	1
Improved health	15	7	8
Couldn't do it on my own	11	8	3
Sharing with others	13	9	4
Increased opportunities	3	2	1
Reason for surgery	17	13	4
Surgery is a tool	19	13	6
Adherence	23	13	10
Decision making	2	1	1
Negative body image	29	17	12
Regret	16	9	7
Secrecy	30	15	15
Unprepared	2	1	1
Needs control	5	4	1
Fear	25	12	13
Complication	15	12	3
Life (food) is different	80	44	36
Change in relationship with food	27	24	3
External interference	21	17	4
Others' perceptions	20	17	3

Formulated Meanings

For each meaning unit, pertinent statements were extracted and meanings were formulated. These formulated meanings were devised to answer the question, "What is the substance of what the participants are saying?" These formulated meanings are typically edited versions of what the participants said and were created by the researcher and a member of the dissertation committee who is experienced in qualitative data analysis; this process validated the formulated meanings. The following are examples of significant statements with their formulated meanings:

<u>Significant Statements</u>	<u>Formulated Meanings</u>
1. I really don't think that probably I would've ever changed jobs had I not lost the weight that I had lost.	I was too ashamed of my weight to try a new career opportunity.
2. But I wanted to be healthy, because, you know, I – I couldn't walk around the mall. I couldn't do any of those sorts of things, and he'd get aggravated because when we'd go on vacation, go to the beach and that sort of thing, um, I didn't feel like getting out and walking and going anywhere.	My partner got frustrated when we'd go places and I wouldn't feel like doing anything active.
3. When we have time, we lock the door when everybody's asleep. It's a lot better. I'm present.	When I was heavy, I would just go through the motions when we had sex; now, I am an active participant.
4. It just feels like I'm being watched, you know?	I still feel stigmatized, even though I'm not obese now.
5. Don't be guilty that you can go drink a half bottle of wine and I'm not going to.	I may not do things I used to do, but you still can.

Themes

The initial clustering of meaning units occurred in the following manner. One overarching *marriage* theme seemed appropriate, since the study was about the description of how the dyad experienced WLS, and since all the dyads were legally married. The cluster of meaning units around this *marriage* theme were: marriage unchanged, marriage changed, sex (better, worse, unchanged), accommodating partner, and life too busy. The next cluster involved *the surgical experience*: both positive and negative occurrences. *Positives after surgery* included the meaning units: more active,

more confident, improved body image, positive experience, concern with others' feelings, improved health, could not do it on my own, sharing with others, and increased opportunities. Four other meaning units were clustered under *the surgical experience*, neither positive nor negative: reason for surgery, surgery is a tool, adherence, and decision-making. The *negative experience of surgery* contained the following codes: negative body image, regret, secrecy, unprepared, needs control, fear, and complications. The meaning units of *life is different* and *change in the relationship with food* were clustered together, as were meaning units *external interference* and *others' perceptions*; this last cluster was tentatively named *external influences*.

These clusters were validated by a member of the dissertation committee with experience in qualitative data analysis. The meaning units were clustered around four themes: *no longer a slave to food*; *good and bad*; *just a tool, not the solution*; and *support and accommodation*. *Change in the relationship with food* and *life is different* meaning units became one theme, since most of the descriptions of how life was different involved food. The next theme described the experience of WLS, both good and bad. The *positive after surgery* cluster became the *good* subtheme, while the *negative after surgery* as well as the *external influences* became the *bad* subtheme. The *external influences* cluster contained negative perceptions of the dyad, so it fit better under this new theme, rather than becoming a theme on its own. The four neutral meaning units clustered under *surgery*: reason for surgery, adherence, decision-making, and surgery is a tool became a third theme. The *marriage* cluster also became a separate theme. The themes were validated by referring back to the original transcripts to determine if any

significant content was not accounted for in the selected themes. The results of the analysis were integrated into themes of the phenomenon of being an intimate dyad that experienced weight loss surgery. This process is also described below in Table 3.

The four central themes were named using the participants' own words when possible. The four themes are: "No longer a slave" [to food]; good and bad, with subthemes of "It's the best thing I've ever done in my life," and "Just let me be normal"; [surgery is] "Just a tool, not the solution"; and support and accommodation. All four themes emerged from analysis of all participants' stories. No one theme was dominant, but all themes came from both the experience of the WLS individual and the partner.

No Longer a Slave to Food. Food no longer had such a dominating hold on their lives. Before WLS, many participants' lives revolved around food. Food was used for everything: for comfort, for celebration, for something to do when bored. After surgery, the WLS individual was no longer able to use food in this manner. The physical restrictions of the pouch limit the amount and the type of food consumed. The relationship an individual has with food must change, and these participants told the story of how their relationship with food has changed.

In some instances, this relationship change was not viewed as positive. Anna commented on how she and Adam used to go on cruises before they had children; in reflecting on their cruises, she acknowledged that it was mostly about eating, since they were not very athletically active. Now she wonders if going on a cruise would be fun for them as a vacation, since Adam cannot eat the way he used to. Ira saw food and alcohol

as fun, as a celebration. He regretted being unable to celebrate in this manner since Irene had WLS.

Eating is just not the same anymore. And Irene is a gourmet cook. She is a wonderful cook, but we have to really watch what we do, you know, with that. So it doesn't...it's not as much fun as it used to be.

Table 3

Clustering of Meaning Units

Meaning Units	Original Cluster	Themes
Marriage changed Marriage unchanged Sex better Sex worse Sex unchanged Accommodating partner Life too busy	<i>Marriage</i>	<i>Support & Accommodation</i>
More active More confident Improved body image Positive experience Concern with others' feelings Improved health Couldn't do it on my own Sharing with others Increased opportunities	<i>(+) surgical experience</i>	<i>Good & Bad Subtheme: Best thing I've ever done</i>
Reason for surgery Surgery is a tool Adherence Decision-making	<i>Surgical experience</i>	<i>Just a tool, not the solution</i>
Negative body image Regret Secrecy Unprepared Needs control Fear	<i>(-) surgical experience</i>	<i>Good & Bad Subtheme: Just let me be normal</i>

Complications

Life is different Change in relationship with food	<i>Change in relationship with food</i>	<i>No longer a slave to food</i>
External interference Others' perceptions	<i>External influences</i>	<i>Good & Bad Subtheme: Just let me be normal</i>
[End of table]		

Ira also felt criticized when he tried to prepare food.

And, um, I constantly seem like I'm being lectured about, you know, "You oughta use water. Don't use butter." You know, don't do this, don't do that, you know? Whatever. And, um, you know, that's probably about the only negative thing.

Several participants commented on how hard it was to eat in restaurants after WLS. The WLS individual can have trouble finding something appropriate to eat, especially in fast food restaurants. Many couples tried to share entrees in restaurants, but some partners felt guilty because perhaps the WLS individual was not enjoying the meal as much as they had before.

When we would go out to a buffet he loved and still tried to eat some of the stuff at the buffet, but before we left he was in the bathroom throwing up. So it's hard to enjoy that sort of thing. We finally just gave up the buffets and said that was the end of that.

It's kind of hard to sit there and eat a full steak in from of her knowing that she couldn't do it, you know. So that was a little rough.

Cooking for the family posed problems for the WLS individual, especially immediately postoperative when the diet is so restrictive. Some WLS individuals coped by just

preparing two different meals - one for themselves and one for the rest of the family. But this extra preparation could cause stress and negative emotions.

And then my husband would say, “What’s for supper?” and I was like (audible sigh), “I don’t know. I have no idea what I’m gonna fix for supper. Here! Drink some of this if you want to know what’s for supper!”

In contrast, many of the stories about how the relationship with food had changed were positive. One participant, Christine, worked in a school cafeteria and explained how her work day was consumed with eating.

So, when you’re working around food and being heavy, it’s not a good thing. I gained 50 pounds just working at the school. I would eat breakfast there. Two hours later I would eat lunch there. And probably not even, we would serve for like an hour-and-a-half and I’d eat something else before I’d go home. I would just constantly...then I would come home, I might wait 30 minutes, and I felt like I was always eating. Then I would eat laying in bed when I was reading. All those habits have changed. You know. Better choices. I don’t eat like that anymore.

Many participants spoke of how changing their eating habits caused their family members to change their eating habits as well. Partners reported eating much healthier after their spouse had WLS. Incorporating more fish in the diet, experimenting with new recipes, and buying groceries that are healthier with no junk food in the house all played a part in the families’ eating healthier. Planning for meals is important after WLS because the WLS individual needs a certain amount of lean protein and is not supposed to consume much bread, starchy carbohydrates, sugar, rice, or pasta. When eating away from home, the WLS individual must plan accordingly by carefully selecting a restaurant where menu selection will not be problematic or by packing appropriate food and snacks

to take along. Several participants discussed how meal planning actually brought the family together more for meals than before WLS.

There's more planning with meals. Meals still remain kind of a cornerstone of the family, when we get the boys and us all together a couple of times a day.

Changing the mindset about food was another occurrence after WLS. Many participants spoke of craving certain foods and being consumed all day with thoughts about what they were going to eat next. WLS changed the thought patterns for many participants.

I didn't have to worry about it. It wasn't a constant conversation of what's for dinner? What's for – you know? I don't know, it just seemed to – it seemed a lot easier. 'Cause I didn't – 'cause food consumed every thought. You know, I get up in the morning, I'm like, *Okay, what am I getting on the way to work?* I get to work. *Where am I going to go for lunch?* And it's just constant obsession and – and when I – and especially when I first went on a liquid diet, it was like, *I don't have to worry about it. It doesn't matter! It's gonna take me two minutes to suck this drink down, and I got the rest of my day.* I was more productive. It was much easier and much better.

Used to, I would crave more and, you know, be a lot more interested in what are we going to eat, I want to have some input into that, but now she really wants me to, uh, what do you feel like you could eat. I don't like to be the deciding factor because my tastes have changed. Most of the time, my answer is, it doesn't matter to me, you know.

The most notable thing is, before the surgery, a lot of our daily function revolved around where we would eat. Now after the surgery, it's like she's no longer a slave to her emotional need to eat.

Celebrations, for some participants, have also changed. Instead of going out to eat for a family celebration, many participants wanted to do something more active instead of focusing on the food.

We ate. Growing up, I mean – and this is my family growing up, and then now it's like, you know, as soon as somebody has a birthday it's like, "Where are we going to dinner?" "Where are we gonna go? Where are we gonna go to dinner?" And my – me – my birthday this year, what I really wanted to do, which we ended up not really being able to do much of anything, but what I wanted to do was to get a kayak for the day. That's what I wanted to do. You know, I – I – I don't want to focus it on the food. Um, we – I take my daughter to the beach. And we go to the pool. We go to the park, um, we walk the neighborhood.

Dealing with the emotional reasons for overeating was something that some WLS participants discussed in the interviews. From overeating as a behavior to alleviate stress to dealing with a food addiction caused by unknown forces or childhood trauma, some participants had to find other outlets to deal with these emotions besides eating.

I was addicted to Cokes, I mean I bet I drank two 2 liters a day, loved them, but have not touched a soft drink in a year. I thought it would be hard, but it's not. The results now are way far amazing than drinking that soft drink. I would probably throw up if I even drank one (laughs). I'm not going back there. I mean, I'm not. Oh gosh, I ate everything fried. Like, and it was like I was addicted to food, honestly.

Yeah. Yeah, it – but it's stress. It's – it's all stress related for me. And work is hard, and I need a new job, and that's how I'm dealing with it. And that's – it's not – and I – I realize I'm doing it, which is better than what I used to do.

You know, I have a food addiction. I know that, and I have to face that every single day. It's not going to go away but it's easier for me to deal with because I can't gorge myself. I'm going to gorge myself on three grapes, so there.

These participants stated that WLS helped them deal with their emotional eating and food addictions because they were no longer physically able to consume their substance of choice in the same manner as before.

You have it in your mind that, *I wanna lose this weight*. But even smelling the food, it doesn't – you can smell it and feel full. So as long as you're full, you're satisfied. So that was the whole key, and so that's what the surgery was about; it kept you full. If I even thought I was hungry I could drink some water and there I was all over again, full, just that quick. I never missed the food or anything. Your – your taste buds are not there for you to even think about– *I wanna eat this*. And so it did – it never bothered me.

WLS helped change the relationship these participants had with food, from physically not being able to overeat to wanting to be more active with their families for celebrations instead of focusing on food. While most examples of this relationship change were positive and healthy, some participants had negative experiences with this newly imposed relationship change.

Good and Bad. This theme explores the experiences of having WLS for the surgical individual and his/her partner; some experiences were positive, while some were negative.

It's the Best Thing I've Ever Done in my Life. All of the participants remarked that WLS was a positive experience. Any negative issues or complications were considered minor to the participants, and the benefits of WLS far outweighed any drawbacks. Many participants could not verbalize any drawbacks; their experiences were totally positive. In fact, most of the participants wished they had WLS sooner than they did. The partners were emphatic about how positive the experience had been:

No, like I say, I'm glad she had it done.

It's awesome. I see that joy on her face when she's able to do those things. That's priceless. In fact, my kids have on various occasions made comments about, wow mom, you're doing this now or, you never would've done that before. They are very proud of her. She set a great example for them that, you know, sometimes things are so important you have to make a stand, you have to make a decision and follow through with it. Absolutely 100% certain, no questions asked. It's been one of the best things for her that she possibly could've done.

It has been a good thing. I cannot say anything bad about it.

The WLS individuals, even having to go through total relearning of how and what to eat, would also not think twice about having surgery.

It's awesome. It's awesome. The best thing I've ever done in my life, I think.

This is...It was worth everything I went through to do it, everything.

Absolutely, much sooner. Being I was 41, almost 42, whenever I had it done. I look back now and think of the years that I spent being way too overweight and the health risk that is, and the fun and the satisfaction socially and personally that I could've gained had I done it earlier, but I think it was always one of these things, I don't need to do this, I can do this on my own. I would try and I would lose 10, 15, 20 pounds and I gain 15, 20, 30. I finally came to the realization, this is necessary. Definitely, yes, I would do it again.

I have. I mean it not only saved me physically, looking back I understand that it saved me emotionally, too, so, I mean, if you want to look at it in a warm and fuzzy kind of way. I would do it again tomorrow, in a New York minute. Even with the low ferritin, even with the emotional aspect I went through, because I think I'm a stronger person for it physically and emotionally. I would do it tomorrow.

More confidence and the ability to be more active were positive consequences of WLS. The ability to buy clothes at any store was a major milestone for many WLS individuals. For the men, going shirtless while doing yard work was something they would have never considered before, but now they do not feel self-conscious without a shirt. This increase in confidence has led to increased career opportunities for some participants. Dale stated how he never would have considered a career change from administration to education had he not lost weight. Irene also discussed how her weight kept her from advancing in her field; this is not a concern after the weight loss as she has changed positions and is a leader in her organization. Partners were aware of this increased self-confidence; many spoke about their spouse's having higher self-esteem, being able to speak more confidently in public, and "feeling better" about themselves.

Becoming more active was an additional positive experience after WLS. Both WLS individuals and their partners spoke of how much more energy the surgical individuals had after WLS. From doing housework instead of collapsing on the couch to kayaking and winning road races, these WLS individuals have experienced dramatic changes in their levels of physical activity. Fewer complaints of joint pain and being able to walk and enjoy themselves on vacation were also mentioned by both WLS individuals and their partners. The ability to enjoy their kids and, in the case of two participants, looking forward to enjoying upcoming births of grandchildren were causes for celebration. One participant and her partner became leaders for a Venture Crew, which is like Boy Scouts for coed teenagers, in which they hike, camp, canoe, and spend much time outdoors; this participant could not imagine doing these types of things before WLS.

For many of the WLS individuals, health was a primary motivating factor for the surgery. Hypertension, diabetes, and sleep apnea were common preoperative complaints for these participants. Christine remarked,

My health was really getting bad. I was starting to lose kidney function. I was a really bad diabetic, on all types of medication.

Two of the participants have serious family histories of heart disease; losing weight and becoming healthier relieves some of their anxiety about developing heart disease. Many of the WLS individuals stated how they stopped taking all of their blood pressure, cholesterol, and diabetes medications after the surgery. Aside from these serious comorbidities, minor health complaints like snoring, achy joints, and increasing immobility were relieved after WLS.

For many of the participants, WLS was the last option. Many had tried every type of weight loss program and had dieted many times, only to fail.

That is the only thing that will get rid of diabetes, they said, is gastric bypass surgery, unless you can lose it on your own, which I could not. I, I guarantee you I tried every fad diet there was out there. I tried everything. I went to the doctor and got diet pills. I done everything. Nothing worked. Nothing. I went to Weight Watchers. I went to Formula 3. I done everything possible. Nothing worked. Nothing.

I would try and I would lose 10, 15, 20 pounds and I gain 15, 20, 30. I finally came to the realization, this is necessary.

‘Cause there’s no way that I could’ve done it on my own and kept it off. I could’ve done it, probably, but it would’ve come back plus some, I – I – guarantee. You know, I tried for years. How many years are you going to try?

WLS presented an option that was scientifically proven to help most people lost a great deal of weight, something other diets and plans did not offer. Two partners commented on the fact that their partners had tried diets repeatedly with no success.

I told her every time she went on a diet, the only thing that ever lost anything was my wallet. [laughs]

WLS provided a more permanent solution for these participants.

WLS individuals experienced improved body image. Jane comments how John liked to buy her lingerie. Christine commented how Charlie holds her hand in church, walks beside her instead of in front of her, and tells her how her face is so skinny; Christine feels they both see her differently now that she has lost weight. Elvira commented:

Even at my heaviest, he always told me every single day that he loved me and I was beautiful. That's important to me. Now I believe him. He's told me that all along but I didn't believe him, because I didn't believe in myself.

Fiona remarked that she feels more romantic; she feels sexier and more appealing to Frank than she did when she was heavy. George talked about how Glenda brags to everyone how small he is now and how he's gone from a "3XL" shirt to a small or medium. Glenda remarked how their son is so proud of George, which makes him feel better about himself.

All participants commented on how positive their experience was with WLS, and all participants stated they would recommend WLS to others. Several WLS individuals

and partners stated while they would recommend WLS for anyone, those persons needed to be well informed and understand the possible risks and complications.

As long as you're confident and you're okay, and you're well informed, and you understand the complications that can happen, and you know the risks, as long as you're fine with that, I say go for it, go for it all day long and two times on Sunday.

I have actually been a proponent for several others that have gone and gotten it since I have. We have had a good support network there just in friends and social contacts I'm aware of that have had that.

I mean, everything has been great, and I recommend it, really to anybody, as long as they're wanting it for themselves and not for somebody else.

The participants had concern for the feelings of others, which was evident in the interview analysis. Dale, in particular, was concerned that his wife or whoever prepared the food was not hurt when something he ate did not agree with him. He does not want anyone to think that he is vomiting because of what was cooked or how it was cooked. Dale wondered if Debbie would want the surgery, but states she has not made up her mind yet to go forward with WLS. He states he would be supportive of whatever decision she made and not only because she has supported him throughout his process. Glenda worried that George would have problems with others eating around him when he could not have the same food, but stated this has not been a problem.

Just Let Me Be Normal. While the overwhelming view of WLS was positive, there were some negative experiences that were discussed. Some WLS participants felt pressure or interference from others both before and after WLS. Many WLS individuals

experienced pressure not to have the surgery from their partners. Fear was the underlying factor in this pressure from the partners.

In fact, he didn't want me to have this surgery. He said, "I love you just the way you are," and he'd heard horror stories about it, and when we went to see the videos and that sort of thing, and then we heard the risks, you know that it's possible I could have died. And he didn't want me to have it done.

Well, I was – seriously, I was very reluctant about him getting this surgery. I was worried about it. I – I was not one hundred percent convinced that he should do it.

Other family members contributed to the preoperative interference.

My cousin who was an ICU nurse over here at (Hospital A) just absolutely clouded up and rained all over me about, "Don't do this. Don't do this. You're liable to die." Um, and then I – I told my – um, my best friend, but I didn't tell her until two days before I had it done. And she absolutely had a fit 'cause, you know, that was still the time when the risk rate was so high.

Some participants continue to feel stigmatized after WLS. Barbara states she feels like she is being watched, whenever she eats at church, with her family, or by strangers at a restaurant.

It just feels like I'm being watched, you know? And when we do have eating situations or like, you know, going to a Baptist church, you eat all the time. (laughs). I mean, seriously, every event you have is – is – is surrounded by food. And, uh, you know, I mean, sometimes I go, and I'll just maybe not eat anything just so people won't see what I'm eating. I mean, I'll just wait till I get home and eat. And – what was it? Somebody's birthday two weeks ago at church, and they had – they had it at choir practice one night. Well, somebody had brought a cake in, and I took maybe – maybe two – two teaspoons of the cake over on my plate, you know. And I just kind of ate it slow and stuff. Well, one of the persons in the choir made a comment to me, "Well, if you keep on eating stuff like that, you're

gonna gain all that weight back.” You know, it wasn’t somebody’s business, you know?

External interference came from family members who want to sabotage the individual’s weight loss. Elvira discussed how her mother-in-law, who resided with the couple, was vain and constantly talked about needing to lose weight while trying to sabotage Elvira’s weight loss by cooking things she was not supposed to eat.

Fear was a negative emotion felt by both members of the dyad. Many partners felt fear preoperatively regarding the outcome of the surgery, mortality, and possible complications. Postoperatively, if the partner was not fully educated regarding expectations, fear was constant.

You know, I don’t know whether it was a secret or – or what, but it was very scary. And when you have somebody who is in that intense pain, you know, of course, to the – the fear of the incision rupturing –

The couples were also afraid of the WLS individual not being able to stick with the regimen and gaining weight.

So, there was that fear playing in the back of both our minds, what if I can’t stick to the program. What if I’m just back here in the same situation 5 years or 10 years later, you know, and now I’ve only got a tenth of a stomach. It’s all stretched back out again and you can’t do it again, all those fears about fear of failure.

No dyad mentioned fear of the relationship dissolving or changing after WLS. Helen stated that she knew Henry was afraid something would happen to her, but he was not afraid of their relationship changing.

A few participants shared a brief feeling of regret immediately postoperatively, but this feeling was resolved quickly. Once the participants were able to consume protein shakes and realize they were not hungry, a sense of empowerment came over them. Barbara was the participant who stated regretting her decision for the longest amount of time:

I cried for the first two months after I had this surgery. Yeah. I did. I cried, and I was like, *What have I done? This is the worst thing I've ever done.* (Laughs) Um, I – I don't know if it was because I was – I don't know. I – I – I don't know, because, you know, I'd go in there and cook and couldn't eat it. And nobody would ever say, "Thank you, Mom," or, "Thank you, honey, for fixing – I know you can't eat it, but –" you know. And I'd get depressed and – because I'd have to go back in there and clean up dishes and things that I didn't even get to eat and – you know. I don't know, I just – I was just – just kind of depressed for the first two months.

However, once the solid food restriction was over, and the weight loss became noticeable, Barbara once again felt empowered by her decision.

Secrecy was a major negative factor in these WLS dyads. Most of the secrecy was preoperative. Some WLS individuals did not discuss the surgery with their partners, taking other friends or family members to the surgeon's office for appointments. Irene mentioned the surgery briefly only a few days before the surgical date and did not educate Ira on postoperative expectations. Preoperative weight was also kept secret from many partners.

She wasn't fat. I didn't realize, you know, that she weighed what she told me she weighed, but when she said she lost 100 pounds, I sat back and thought, whoa, you pulled the wool over my eyes, because we never discussed the weight. We never sat down and discussed the weight.

And, even when I went to see [Dr. X] to have the surgery, I didn't take him, I took my best friend, because I'm not sure he even knows what I weighed. I never told him. I was just too embarrassed. I don't know if he even knows how much I weighed because I always kept that from him. I would never tell him that. I mean, cause, when we got married, I weighed like 125 pounds and I had gained up. My heaviest weight was 254. So, now I'm at 159.

One participant, Barbara, chose to keep her WLS a secret from others even today.

And, at first, I would tell people I had surgery, and now I don't. When I see people that hasn't seen me and don't know, they'll say, "Barbara, you look so good! How'd you lose all that weight?" I say, "Oh, I just watch what I eat." I quit telling them because I think people watch you after you've had that surgery. They watch every bite you put in your mouth.

A pervasive negative body image was apparent throughout the interview transcripts. Many of the WLS individuals struggled with a negative body image before surgery. They did not want their partners to see them without clothes; they were embarrassed and ashamed of their looks and how they "had let themselves go."

Well, because I had just let myself go so much and had gained so much weight. I was just embarrassed about how I looked, how I felt. I had gotten myself into being a diabetic, um, I was losing kidney function. I just felt just horrible about myself, you know.

Fiona discussed seeing someone bigger in the mirror than her true self. She feels bigger at times than her actual size. Partners commented on this pervasive negative body image.

I would say my wife's self image is probably always going to be a sore spot with her. It's something she's very sensitive about and her physical appearance. You know, she'll try on 3 or 4 outfits before we go somewhere. It's like, *does this look okay?* I'll say, *honey, you look great*, but it's like she doesn't believe me, and I don't know if every wife does that or if that's a function of her personal history of where she's been or where she is now, that she's just not trusting her

eyes when she looks in the mirror. I don't know what she sees through her eyes when she looks in the mirror because of the history that she brings, but I know she looks fantastic.

Well – well, primarily, even though she has, um, um, maintained, uh, um, her weight loss, um, she still feels, in her mind, that she's heavy.

Um, and, again, I think it's also, too, because she sort of shies away from that, uh, because she sees herself as being twice as big as she – she is.

Only a few participants commented on excess skin being problematic, but most considered it a minor annoyance that did not affect their overall self-concept. Jane mentioned her arms bothered her, but not enough to pay for plastic surgery; she chose to wear longer sleeves. The excess skin is not bothersome to her. Helen also mentions feeling flabby and how it makes her feel less attractive at times, but as she states,

Yeah. Yeah. I do – yeah, um, the skin thing's kind of annoying, sexually, you know, I was like, *I want to be able to wear something cute and* – you know. (Sighs) I've got all this flabby stuff. But I've – you know, I keep saying to myself I'd much rather be flabby and thin – not necessarily thin but flabby and healthy than to be hot and fat. I just – (Laughs) You know, I – I'd much rather have some skin than to have the fat, so that's something I've had to kind of just deal with, and he doesn't care.

Christine discussed having an abdominoplasty; her abdomen is her problem area with sagging skin, not only from weight loss but from pregnancies and Cesarean sections. However, she states this surgery is not on her priority list. She states she is not happy with her stomach, but it is not anything so bothersome as to have plastic surgery.

Physically, very few of the WLS participants experienced any type of surgical complications postoperatively. Elvira developed low ferritin levels about two years after

WLS; she had to have outpatient iron infusions for a period of a few weeks to get her ferritin levels back to normal. She stated this was a minor complication in her view, and it did not detract from the overall positive experience she has enjoyed postoperatively. Irene had the most severe complication; she began passing a renal calculi in the recovery room and was overmedicated for pain, causing a respiratory arrest. This event did not prolong her hospitalization; however it caused much distress for Ira and her children. Irene also experienced some short-term memory loss in the months following her surgery and also developed an adrenal disorder that has caused her to gain weight. This adrenal disorder was probably not induced by the WLS, Irene stated, and she has experienced a significant number of non-related health issues after her WLS. Barbara has experienced some emotional and physical issues postoperatively. Sex is painful for her, due to the loss of tissue in her perineal area, which is exacerbated by menopause. Another complication she experiences is stress incontinence, which may be linked more with her age than with her weight and tissue loss in her perineal area. Behaviorally, she has developed obsessive-compulsive tendencies, which cannot be directly linked to her WLS. These tendencies cause her to need to be in control of everything in her environment; “everything had to be done just right.” These tendencies manifested in her work environment; she works at a church daycare and realized she was being too harsh with the children when they did not follow directions immediately. Barbara has sought help for this problem and that anti-anxiety medications have helped. Irene also complained of needing to be in control; this is why she does not drink anymore, especially in public,

which is what Ira laments. She absorbs alcohol much faster than before WLS, so a small amount can make her lose control. Therefore, she chooses not to drink in public.

Overall, the negative consequences of WLS were relatively minor for these dyads, and no participant claimed the negatives were too much to bear. They accepted these minor inconveniences as something they cope with, because the benefits of losing weight are far greater .

Surgery is Just a Tool; It's Not the Solution. Many participants expressed this thought. Surgery does not change the emotional or psychological aspects of overeating. Individuals who chose to undergo WLS can expect to lose weight, but they must adhere to the regimen and deal with their emotional issues in order to be successful. Anna discussed how some of Adam's habits had resurfaced:

But that's changed as we've gone – sometimes I get real concerned because the mind is not changed with gastric bypass. The, um – the emotional eating, the eating at night, that has resurfaced, so in that part I'm kind of disappointed that – that didn't completely – it can't cure the mind, it's still going to be there, so – Um, I guess still my fear of him resort – you know, resorting back to the same eating behaviors. Like I said before, the mind has not been fixed – you still eat for the same reasons because none of that was ever addressed. You don't – even the psychological evaluations before surgery, I don't think, are adequate. I think – you need more, um, soul searching. The diagnostic – what is it, the MMPI? The, um, psychological test you take? That doesn't provide any information. That doesn't tell you what that person's going to be like when they're done. And so, um, it would almost be good for patients to do journaling for several months before, to get to the root of what their eating problems are, why they are overeating, what their activity's like, you know.

Likewise, Eustice was aware of what Elvira needed to be successful.

That's nice as a deterrent but I think more than that, in preparing for the surgery, she was required to go for a psychological evaluation and for some counseling,

and that forced her to start dealing with the emotional side of her eating disorder. That, I think, equal to or more than the surgery, is something that she absolutely had to confront. She had to confront that demon and realize, I'm eating because I'm emotional. I'm unhappy, I eat. I'm happy, I eat. I'm frustrated, I eat. I'm exhausted, my husband is driving me crazy, I eat. Ultimately, the weight loss surgery is just a tool, it's not the solution. It's just a tool. She still had to find that motivation from within to realize, I've got a problem with eating, and I've got to stop. I've got to get a grip on this and to be able to use the weight loss surgery as a tool to help her.

Many participants expressed the concern that the preoperative psychological testing was not enough. Postoperative therapy may be needed as well. Some WLS individuals underestimated the emotional impact of WLS. Helen and George both stated how serious postoperative individuals need to take their new lifestyles; it has to be a mental breakthrough to truly change one's lifestyle. While initially the feeling of fullness enables the WLS individual to eat less and lose weight, these participants realized it was not the cure nor the solution, but merely a tool to feel full quicker and initially lose weight quickly in order to help give motivation to change their lifestyle permanently and to therefore enjoy long-term success.

Adherence to the medical regimen was identified as a major component of success after WLS. WLS individuals commented on how strict they followed the regimen and how they discussed this with others who were considering the surgery.

George commented:

But I tell them, I said, I'm not really the nice person to talk because I'm very, very strict or adamant about eating and, you know, um, about things, what you do or don't do. And I said the problem is I listen to people in the lobby talk about they're not gonna drink any water or they ate some ice cream and it didn't bother 'em and this and that. And I said, you know, the first thing I would tell people, if you're planning not drinking water, that you need to drink the fluids. If you're

planning not exercising or eating right, then you just should carry your ass out the door and don't waste the insurance and doctors' time 'cause you'll have your tail right back where you were.

Charlie expressed pride at how Christine has adhered to her regimen. He stated that she does what she needs to do and is not affected by what he drinks or eats. He commented that they both knew what the regimen would be like postoperatively, and she "has stuck to it like a trooper."

While WLS participants expressed the knowledge of surgery just being a tool, the underlying reasons for undergoing the surgery revolved around health issues. Many WLS individuals expressed concerns over their health as the primary impetus for WLS. Resolving diabetes and hypertension, preventing heart disease, improved sleep apnea and snoring issues, and the desire to stop taking medications were the primary reasons stated by WLS participants and partners for surgery. Only one partner, Ira, stated that Irene's motivation may lie with emotional reasons:

And also, too, there is prejudice towards people who are heavy. She was concerned about her career - a professional, you know. Even amongst, um, medical professionals, there's prejudice.

The WLS individuals took this decision seriously; many of them contemplated and researched the procedure and its outcomes for up to a year or two before contacting the surgeon to determine eligibility.

Participants were committed to adhering to their regimen and understood that emotional changes must occur along with the physical changes in order to lose weight

and maintain that weight loss. The surgery is just one piece of many that lead the participants to a healthier life without excess weight.

Support and Accommodation. All of the participants commented on the support and accommodation that were needed from within the dyad in order to cope with the radical lifestyle change after WLS. All of the WLS individuals commented that they received positive support after the surgery. Jane stated:

He was there from the minute I – from the moment I opened up my eyes to now, he’s been very supportive. He – he never left the hospital, never left my bed. He walked me. He encouraged me. You know, he – he made sure I – I ate what I was supposed to eat. He went on diet – the diet with me. He lost a whole lot of weight after I had the surgery, too, so he was right there. He was – he was good. He was a very support part – uh, good support partner.

The WLS individuals spoke at length about how their partners supported them through this time of adjustment to the new regimen, from making sure what they needed to eat was available to changing behaviors in order to be more congruent with what the WLS individual was doing.

He’s been really good about trying to be understanding and trying to change his behavior to help me, and I know that I’m very blessed in that regard because different ladies and men that I’ve encountered in different support groups and stuff, going back to [city] back and forth every once in a while don’t have that. I think it’s kind of like alcoholism. If you have two people that drink and one of them decides to dry out and this other one is still drinking or bad health habits, there’s going to be a clash.

Cooking different meals for the WLS individual versus what is prepared for the rest of the family is another way the individuals felt supported by their partners. Sharing an entrée at restaurants, even when the WLS individual knows the entrée is not something

the partner would normally order is an example of how one WLS individual felt supported. One WLS compared his nurse wife to a drill sergeant; ensuring he did what he was supposed to do constituted support for him. Allowing the WLS individual to exercise and take whatever time is needed to follow the regimen was considered supportive. Never fussing or nagging when one would “fall off the wagon” was considered supportive, as was saying things in such a manner as to help the WLS individual “get back on track” with the regimen without being critical or negative.

Only one WLS individual claimed to not have been supported fully by her partner. She stated they had a rough few first months immediately postoperatively; she felt unappreciated when she cooked for the family and she could not eat it. She goes on to say:

Well, you – you probably know. But the first two months is (pause) – was very, very hard. And, of course, you know, he’d say, “Well, I told you not to have this surgery done. You don’t have anybody to blame but yourself.” So, I mean, you know – but – but this surgery was for me, and I try to explain that to my husband as well, you know, and I said – not that he’s been critical. I mean, a couple of times, you know, a few things I’ve mentioned. And he has been supportive as a whole. I’d say ninety-five percent of the time he’s been supportive.

All other WLS individuals claimed feeling fully supported through this change.

Partners expressed how they supported their spouses during this transition. One partner described how he ensured his partner had whatever protein she needed on hand in the pantry, without her having to ask. Encouraging her partner when he realized he was regaining weight was a big role for one participant; she admitted to not being the best communicator and would rather say nothing that hurt anyone’s feelings. But she was able

to tell him what habits she had observed, like eating something salty followed by something sweet and eating at night which may be causing him to gain weight. She believed making him aware of these habits even though it made her uncomfortable was how she supported him. Not eating out at certain restaurants was another example of support. One partner discussed how he was mindful of what he ate in front of his spouse. One partner prepared anything for her spouse that he felt like he could eat, even though it meant cooking two different meals; this was one of the ways she showed support. Another partner acknowledged the time her spouse spent away from her in exercise and physical activity may be excessive, but she realized he is much happier when he can do these things, and she did not let his racing interfere with their plans. She was very conscientious of his exercise/race time, and she made plans for them around that time. One partner expressed how he thinks he is more protective of his spouse after WLS and was more sensitive to her feelings about her weight, but his protective feelings were attributed to his lack of knowledge regarding complications of WLS or if something else was wrong. This partner expressed some frustration with the level of support his spouse seemed to need.

Um, you know, "I'm not feeling good. I'm not –" You know, whatever. It was getting to the point like it was like, you know, hey, I can predict what you're gonna say, "I'm not feeling good." I'm – I'm feeling tired of it.

All dyads stated improvements or no change in their relationships after WLS. The participants felt like their marriages had improved somewhat or remained the same with no major effects from the WLS. One WLS individual stated how strong her

marriage is now, because they had to deal with her childhood abuse as the root of her eating addiction after WLS. Learning how to communicate has made their marriage more open and stronger. One couple has become more active in church and have done a few Bible studies on marriage after her WLS; she feels she would not have participated in these activities when she was heavy and self-conscious. Another dyad has undergone many major life events in their relationship: infertility, a child with a chronic illness, a child with behavior problems, two graduate degrees, and several relocations for her career. She stated their marriage is better now, that their lives have settled down, and does not attribute much of their improvement to the WLS. Barbara states she and Bill have been married for thirty years; WLS has not changed their relationship.

No, I mean, we have a good relationship, but, uh, like we've been married for thirty years. I mean, I get on his nerves, he gets on my nerves. (Laughs) It doesn't have anything to do with the surgery, but – but, yeah, I, uh – you know, we had a – we had a good relationship before. But – but, yeah, it, uh – and it's took us, you know, a little adjusting to get to that point. But, all in all, it's been a good – good thing for me and for him, and it's been good – I mean, we still have a good relationship. I mean, we haven't talked – I mean, nowhere near talked about divorce. I know other couples I've heard have split up.

Several couples discussed how they believe their marriage has not been changed from WLS. One dyad stated they are so busy with work, higher education, and children's activities that WLS did not impact their lives much. Eating habits and activities may have changed for one couple, but the emotional aspect of their marriage was unaffected.

Varied responses were given by the participants regarding their sexual relationships. Some participants agreed that sex was better because it is physically easier to perform without the excess weight and with the shrinkage of the abdominal pannus.

Dale also remarked how less taxing sex is now that he has lost weight. Decreased joint pain and increased self-esteem helped participants enjoy a more fulfilling sexual relationship. Both John and Frank enjoy their partners wearing lingerie to spice up their sexual relationship. Elvira perhaps said it best:

I think positively, because neither one of us feels like we're going to die. We don't talk about it and roll over and call that oral sex (laughs). It used to be, I didn't feel good about myself. It got to the point that the heavier I got, I didn't feel good about myself, and then, of course, after the gastric bypass, we had to deal with the intimacy issue with me just finally dealing with the abuse. We got through that hell of a year in that regard, but intimacy is good. When we have time, we lock the door when everybody's asleep. It's a lot better. I'm present.

For some participants life was just too busy to notice a change in their sexual relationship. Several WLS individuals and partners stated that they are just fatigued from working all the time and being so involved in children's activities to have much of a sexual relationship, but WLS did not affect this aspect of their relationship. For some participants, the attraction to their partner was still present, but they believed they had entered an age where sex was not as important. External stressors, such as financial concerns, a teenage pregnant daughter, and graduate school, had more of an influence on libido than WLS. The only participant who stated sex was worse after WLS was Barbara. The loss of perineal tissue has made sex very painful for her. She has sought medical treatment and is being treated for menopause as well, but the treatment is not totally successful.

Summary of Themes. Four themes were identified from the meaning units and clusters. These themes describe how the participants viewed their experience of being a

dyad in which one member has undergone WLS. These central themes were: *No longer a slave*, which described how their relationship with food has changed; *Good and bad* (*The best thing I've ever done* and *Just let me be normal*), which told the story of both the positive and negative experiences after WLS; *Just a tool, not the solution*, which related to the lifestyle changes both partners needed to make and support in order for the surgery to be successful; and *Support and accommodation*, which told the researcher what the WLS individual and the partner needed and received in terms of support and compromise after WLS.

The themes in this study captured the essence of the dyad after WLS. The themes described the experiences of the dyad and highlighted the needs of the WLS individual during the postoperative transition period.

Dyadic Analysis

Using the dyadic analysis method outlined by Eisikovits and Koren (2010), a second analysis was performed, focusing on the couple as the unit of analysis. The researcher studied the individual's perceptions and understandings in the context of their joint life. This examination allowed the researcher to examine the similarities and differences between the two perspectives. Significant statements were compared between the individuals in each dyad to determine if any unique themes existed from the dyadic perspective.

Using overlaps and contrasts, the individuals' significant statements were compared to those of the partners. Few contrasts were found, and most of the dyads' statements were found to be overlapping on all levels (descriptive and interpretive). In

fact, sometimes the descriptions were almost identical. Dale and Debbie's description of their sexual relationship is an example.

[Dale] Probably the biggest influence on that is that we have a little boy that wants to sleep with us all the time. That, of course, plays a big role. That's the big thing.

[Debbie] No, other than the 6-year-old still in the middle of our bed that won't get out. He claims he's moving out in two weeks when he turns 7, so we'll see.

Even in the case of Ira, whose view of his experience after WLS seemed mostly negative, his partner, Irene, knew how Ira would respond in his interview. She stated her opinion but acknowledged and predicted how Ira would react.

[Ira] You know, and that, I have a little bit of remorse for that because, uh, we just don't, uh, do that anymore. Um, going to a restaurant, um, here is not a celebratory thing anymore. Um, um, because for – for a couple things. Number one, she can't, um, eat. I don't, I don't want to enable, um, her overeating, but also if she does overeat, then she has, um – I can't remember the – the word, but it – it – it, um – it is like a backwash –

[Irene] You know, um, that's what I would probably say, 'cause that's been the hardest thing for us. You know, Ira says – Ira will say sometimes, um, we just – we just can't celebrate like we used to. Well, what's "celebrate like we used to" got to do with it? I can celebrate. I'm still alive. I didn't throw a clot. I haven't died. I mean, you know?

The few contrasts that were found were particular to Barbara and Bill and Charlie and Christine. Barbara was more open about feeling unappreciated when cooking food for her family she could not eat. She was frank when discussing Bill's snide comments in reply to any complaints she had postoperatively. The openness of her discussion about

sex and how uncomfortable it was indicated an increased comfort level with the researcher and about the personal nature of the topic. Bill, on the other hand, did not mention any of these incidents. He stated their marriage was good. He did admit to not wanting her to have the surgery, but he believed he supported her decision and gave her what she needed postoperatively. From his viewpoint, their sexual relationship was fine. This contrast does not mean that Bill and Barbara are no less of a dyad. Bill's description could have varied for several reasons. Maybe he truly did not remember making those comments, or he felt uncomfortable with the female researcher discussing private issues such as his relationship and sex. Perhaps Bill was unaware of Barbara's true feelings during that time.

Charlie and Christine's interviews were identified as having some contrasts as well, in the terms that both interviews contained much more "I-ness" than "we-ness". Christine perceived Charlie was ashamed of her before her weight loss. Everything she did revolved around him and his feelings toward her. She even kept her weight a secret from him and took a friend to her preoperative surgeon's appointments. Charlie's interview was self-centered, so in a sense, there was congruence between their stories. He discussed how her regimen affected him; it did not bother him to eat or drink what he wanted to even though she could not have those items. He mentioned several times how he wished she would have had the surgery earlier, so her skin would have been more elastic and bounced back more than it has. Charlie spoke of how he had all his needs met, that Christine never withheld anything from him. When asked how he supported her, he admitted to not appreciating everything she had done for him. His statement was that

even though she would say she had WLS to eliminate diabetes and her medications, he knew she did it for him. Both Charlie and Christine discussed how her snoring affected Charlie's sleep, and how she continues to sleep in a separate room so that she does not wake him up even though her snoring is much improved. This couple shows a great deal of "I-ness" in their interviews. Everything in their relationship seemed to center around Charlie.

There were no unique meaning units for either the WLS individuals or their partners. The meaning units were fairly equally identified between both the surgical individuals and their partners. Upon dyadic analysis, the majority of the dyads exhibited much "we-ness" and overlap on their descriptions. Few contrasts or lack of awareness was noted. Therefore, no new themes specific to the dyad as the unit of analysis were formulated.

Reflection on the Findings

The purpose of this study was to understand and describe the experience of the dyad in which one member had undergone WLS. The findings as described were gleaned from semi-structured face-to-face interviews with both members of the dyad. Four themes emerged in describing this experience. For the participants in this study, couples who had one member have WLS, it means that surgery is not the solution to the weight problem; it is merely a tool to be used appropriately to help lose weight. It means that both good and bad experiences can be expected. The relationship one has with food will change. Support and accommodation from both members of the dyad will make the new lifestyle transition easier and more manageable.

Summary

This chapter provides an overview of the twenty study participants in ten dyads. Data were collected from each member of the dyad in semi-structured separate interviews that were conducted face-to-face. The research question was, “What is the experience of the dyad in which one member has undergone WLS?” Transcribed interviews were used to identify significant participant statements, from which meaning units were extracted. These meaning units were used to formulate meanings that described the phenomenon of having WLS as part of a dyad. Four distinctive themes were developed and validated by the descriptions of the participants. A second dyadic analysis was performed; no new themes were developed. The initial thematic structure accurately identified the experience of the dyad in which one member had WLS.

CHAPTER V

DISCUSSION

Introduction

The purpose of this study was to describe the experience of the intimate dyad after WLS. Twenty participants, who represented ten dyads, were interviewed using an open-ended, semi-structured approach. Participants' narratives revealed four themes as discussed in the previous chapter: (1) *No longer a slave to food*; (2) *Good and Bad*, with subthemes of *It's the best thing I've ever done* and *Just let me be normal*; (3) *Surgery is just a tool, not the solution*; and (4) *Support and accommodation*. This chapter explores the meanings of the themes and participant experiences in relation to current theory and past research. Implications for nursing practice and nursing research, including future research recommendations are discussed. Finally, study limitations are presented.

Themes

No Longer a Slave to Food

This first theme described how participants embodied a changed relationship with food. Participants no longer used food as a crutch or a comfort. Food was something easy to obtain that made the participants feel good. Food was used for celebrations as well as for sad occasions. Most family events revolved around food, such as vacations and holiday affairs. After WLS, this relationship with food changed. The smaller pouch made it virtually impossible to gorge oneself on vast quantities of food. The type of food

consumed is different. Many starchy foods, like bread, pasta, potatoes, and rice, are prohibited by bariatric surgeons and nutritionists after WLS, since they can swell in the pouch, causing stretching and pain. Sugary foods may cause dumping syndrome, an uncomfortable side effect of WLS (Grindel & Grindel, 2006). These factors make it less likely that a WLS individual would use these types of foods when eating for emotional satiety.

The WLS individual and family experienced an increase in physical activity postoperatively. Increased energy and stamina lead to more physical activities, especially those done outdoors, like hiking, kayaking, bicycle riding, running, and camping. Many WLS dyads stated that family celebrations are spent outdoors doing something physical instead of eating at a restaurant. This signifies a significant change in the relationship with food; healthy substitutes, like activity outings, are used for family time instead of focusing the time on eating.

After WLS, eating does require some planning. It is difficult for a WLS individual to find something appropriate for the diet at every restaurant. Fast food restaurants can be especially hard to find appropriate food to consume. Some dyads chose to eat more at home, where something healthy and specific to the WLS diet can always be found. Some dyads planned ahead and ensured good food was brought along on family activities to decrease frustration caused by fast food restaurants. An adequate supply of protein needed to be available, at home or away, for the WLS individual.

Good and Bad

WLS is a life-changing event and can have positive and negative consequences for the individual and the dyad. While the majority of the participant interviews discussed the positive experiences after WLS, there were some negative experiences revealed.

It's the Best Thing I've Ever Done in my Life. All of the participants, both WLS individuals and their partners, stated that WLS was overall a positive experience, and one they would repeat if necessary. The weight loss produced incredible effects for these participants. All participants stated a noticeable increase in energy, which led to increased physical activity and increased time spent with the family. Those participants with young children commented on their ability to play with their children, whereas before, they did not have the energy or desire to do anything other than sedentary activities. Along with this increased activity was an increase in confidence. Participants did not think they were being stared at or ridiculed for their obesity after WLS. They were able to go shopping, to walk on a beach holding hands with their partner, give public presentations for their job, and even switch career paths due to this increased confidence. These findings are consistent with studies performed by Bocchieri et al. (2002b) and Wolfe and Terry (2006).

An improvement in their health was another benefit cited by the participants. Hypertension, diabetes, and sleep apnea were resolved in all affected participants. Freedom from having to take medications or monitor blood glucose levels was a positive outcome. Most of the participants cited their health problems as the primary reason for

undergoing WLS. The amelioration of their comorbidities was the primary outcome most of the participants were seeking, and this goal was achieved by all participants.

Improvement of their body image was noted by WLS individuals and partners. Wearing properly fitting clothing and not hiding behind baggy, oversized apparel was cited by participants as a benefit of WLS. Some WLS individuals and partners spoke of wearing more revealing clothing and sexier lingerie and feeling more attractive to their mate as a result of weight loss. The participants spoke of feeling more positive about themselves after WLS, which echo findings of studies assessing positive psychosocial factors after WLS (Bocchieri, et al., 2002a, 2002b; Shiri, Gurevich, Feintuch, & Beglaibter, 2007; van Hout, et al., 2009).

WLS was necessary in the minds of these participants. Many of them spoke about how they had tried to lose weight on their own previously, many times, and the amount of money they had spent on diet programs that failed. WLS was the end choice, the last chance to get healthy and lose weight. These participants expressed frustration at not being able to lose weight on their own, but were thankful for this procedure that finally made them successful at weight loss.

The WLS procedure was successful for all participants. All WLS individuals and partners would recommend the procedure for anyone who needed to lose weight, with the proper preparation and education. Many dyads had spoken to other people about their experience and recommended it for others. One participant speaks at a local support group and at WLS seminars at the request of his surgeon because he has been so successful with the procedure and resultant lifestyle changes.

These positive findings are echoed by many studies (Bidgood & Buckroyd, 2005; Bocchieri, et al., 2002a, 2002b; Canetti, Berry, & Elizur, 2009; Dixon et al., 2009; Sutton & Raines, 2007; Sutton, Murphy, & Raines, 2009b). Improved psychosocial outcomes, such as increased confidence, self-esteem, and body image, are common findings after WLS.

Just Let Me Be Normal. Not all experiences after WLS were positive. There were some negative consequences expressed by the participants. Physical complications were rarely reported in this sample. One participant experienced a low ferritin level two years postoperatively that required outpatient iron infusions. This was considered a minor inconvenience for her and did not mitigate her positive outcomes. One participant experienced over-sedation immediately postoperatively and briefly arrested; this same participant is now coping with an adrenal dysfunction whose etiology is undetermined. Painful sexual intercourse was reported by one participant as a result of decreased perineal tissue. Regardless of these experiences, both members of these dyads would undergo WLS again for the positive benefits encountered.

Negative psychosocial outcomes were not uncommon experiences for these participants. Initially, most participants described feeling fear regarding the unknown outcomes of WLS, and some regretted the surgery in the immediate postoperative period. This fear and regret was soon replaced with excitement as they started losing weight. A few partners and WLS individuals expressed a pervasive negative body image, stating they felt larger than they actually were which substantiates the findings that the person

continues to view themselves as obese even after WLS (Adami, Meneghelli, Bressani, & Scopinaro, 1999; Camps, et al., 1996).

Keeping the surgery a secret from family and friends was expressed by some participants. Two WLS individuals did not bring their partners to the preoperative appointments with the surgeon, and many individuals made the decision to have WLS without the approval of their partners. One partner expressed his frustration at not being properly educated about postoperative expectations and possible complications; his wife admitting to withholding her decision from him due to her embarrassment and shame. Even after weight loss has occurred, some WLS individuals keep their surgery a secret from others, because they perceive others watching what they consume and feeling judged for their decisions. Applegate and Friedman (2008) discussed this phenomenon of an outside person continually monitoring food intake after an individual had WLS and called it the “food enforcer.” Findings from Sutton, Murphy, and Raines (2009a) corroborate these experiences; participants in their study commonly kept WLS a secret from family and friends for fear of being judged and due to shame.

WLS can cause both positive and negative consequences for the individual. The positive outcomes in this sample outweighed the negative outcomes, according to the participants. The negative consequences seemed minor to them, or was just something to be dealt with, as a result of WLS. All participants would have the surgery again and would recommend it to others.

Surgery is Just a Tool; It's Not the Solution

WLS has proved to be effective in helping obese persons lose a significant amount of excess weight. However, WLS is not a “quick fix” solution for obesity, as the participants stated. WLS requires a complete lifestyle change, ranging from the foods eaten to the types of fluids consumed to the amount of exercise required daily for long-term success. WLS does provide a physical restriction to overeating, but the emotional reasons for overeating are still present. The WLS individual must discover alternative methods of dealing with emotions and stress instead of eating. Several participants stated that WLS did not fix the mind; it was only a part of the solution for their obesity. These findings are consistent with those of Grimaldi and Van Etten (2010), who state that after WLS, individuals have to find other coping strategies to deal with tendencies to emotionally eat. Exercise or some other kind of physical activity is recommended in place of eating when one is bored, tired, upset, or for comfort or distraction (Grimaldi & Van Etten, 2010). These participants were using appropriate substitutions for emotional eating and for culturally-centered eating, such as eating surrounding family events and celebrations.

Adherence to the postoperative regimen is essential in maintaining weight loss. Participants identified this need to “stick to the plan” as an important factor in their success after WLS. Many studies have attempted to identify factors that predict adherence to the prescribed regimen (Boeka, Prentice-Dunn, & Lokken, 2010; Canetti, et al., 2009; Elakkary, et al., 2006; Hildebrandt, 1998; Odom et al., 2009; van Hout, et al., 2009; Zijlstra, Boeije, et al., 2009; Zijlstra, Larsen, et al., 2009). Intrinsic motivational

factors appear to be the greatest predictor of success after WLS, while increased levels of binge eating and emotional eating were associated with more weight gain.

Support and Accommodation

All participants discussed at length how they supported each other during this time of transition after WLS. Support and accommodation by both members of the dyad was considered essential by participants in order to navigate the changes postoperatively. It was interesting to note that the WLS individuals, in many cases, discussed how they supported their partners during this time, by cooking different meals or making sure their partners' needs were met. The researcher anticipated that the WLS partner would need most or all of the support; however, the WLS partner gave support as well. The majority of all participants claimed to have all of their physical and emotional needs met by their partners after WLS.

Types of support and accommodation varied among participants. Ensuring appropriate food was available for the WLS individual was viewed by many participants as being supportive. The participants cited the ability to talk about anything, including fears and concerns, as being supportive. The willingness to compromise when preparing meals or eating at restaurants was considered accommodating and supportive; the partner may order something atypical in order for the WLS individual to share the meal instead of ordering something preferred but not allowed on the diet. The allowance of time for physical activity and the pursuit of personal goals was defined as supportive by some participants. Partners commented they would do anything their spouse, the WLS individual, needed in order to help them be successful on this journey. The WLS

individuals recognized the sacrifices made by their partners and were appreciative of the support and accommodation received during the transition period. No specific studies were found that assessed support and accommodation from intimate partners after WLS. Grimaldi and Van Etten (2010) discuss how adaptations are necessary from the partner and family of the WLS individual, but no study was found that actually measured or discussed how the partners supported the WLS individual. Therefore, these findings are unique.

Overall, the participants stated that their marriages had changed for the better or unchanged after WLS. For those who reported no change, statements were made that they had a good marriage before WLS, and WLS did not change their relationship, which was similar to the findings of Rand et al. (1984). A majority of the participants claimed a better or unchanged sexual relationship, due to decreased abdominal girth and increased confidence and self-esteem. These findings are similar to findings presented by Goble et al. (1986), Rand et al. (1984), and Rand et al. (1982) who all reported unchanged or bettered marriages after WLS due to increased self-confidence, improved sexual functioning, and increased marital satisfaction. Another study specifically found increased sexual functioning after WLS due to decrease in the size of the abdomen (Camps, et al., 1996). Interestingly enough, many of these participants stated their marriage was unchanged after WLS; however, the stories they told indicated major lifestyle changes had occurred. The way they celebrate is different; they are more active, and the things they do together with their children are different. While these participants'

emotional relationship may have not changed after WLS, their lifestyles, and therefore their physical relationships, have changed.

Integration of the themes provided an exhaustive description of the experience of the dyad after WLS. Dyads after WLS must provide each other with support and accommodation during the intense period of transition, compromising and finding solutions that work for the dyad and the family. WLS produced both positive and negative experiences. While for these participants, the positive experiences outweighed the negative consequences, this may not be the case for all. The dyad needed to be aware of potential negative consequences and dealt with them appropriately if they arose. The WLS dyad understood that WLS is not a solution, but a tool that they have used to thus far achieve long-term weight loss. Adherence to the regimen was vital to maintain weight loss, and the dyad needed to implement awareness of harmful eating habits and replace those habits with healthy alternatives. Finally, the dyad experienced a significant change in their relationship with food. Vacations and family celebrations no longer revolved around food, and food was no longer used for comfort or for emotional distress.

Dyadic Analysis

While the dyadic analysis did not produce any new themes or variations on the existing themes, these findings are important in themselves. These couples were truly dyads, acting as one unit. Their stories were similar and almost word-for-word identical in some cases. They reacted to the WLS in such a manner that achieved homeostasis for the relationship. The couples had lived together anywhere from ten to thirty years; they truly knew each other as well as themselves. These dyads were committed to each other

and to the dyad remaining intact; they were committed to dealing with whatever occurred to achieve each other's well-being and satisfaction. These dyads exhibited much "we-ness," with their stories overlapping on both descriptive and interpretive levels; little to no contrasts were noted, which indicated a level of oneness between both members of the dyad (Eisikovits & Koren, 2010).

Implications for Theory

This qualitative descriptive study was influenced by Bodenmann's Theory of Dyadic Coping (2005). This theory is represented by a stressor for one dyadic member eliciting a communication process by which the partner is made aware of the stressor. The partner then responds to the stressor and employs some form of dyadic coping, positive or negative. The overall goal of dyadic coping is homeostasis of the marriage and a return to prestressor functioning.

The participants in this study demonstrated both problem-focused supportive dyadic coping and emotion-focused supportive dyadic coping. Supportive dyadic coping means that one partner helps the other to deal with stress. Problem-focused dyadic coping involved compromising with food choices, ensuring proper food was available, cooking different meals for the family, and coping with physical complications, such as painful intercourse and low ferritin levels. Emotion-focused supportive dyadic coping was exhibited by the couples when dealing with the reasons for emotional eating, past childhood abuse, and offering support and comfort whenever the WLS individual expressed regret or fear postoperatively. The WLS individuals expressed their stress appraisals effectively; their partners interpreted these signals appropriately and helped the

individual cope appropriately with the stressor. Common dyadic coping involves both partners experiencing the same stressor and attempting to manage the situation by joint coping. There was no evidence in the experiences shared by the dyads that the partners of the WLS individuals experienced stress as a result of WLS; therefore, supportive dyadic coping was used more frequently in this sample.

Some examples of negative dyadic coping were expressed by a minority of the dyads. Sarcasm was used by one partner when the WLS individual expressed feelings of regret after her WLS; this is an example of hostile dyadic coping. While this participant stated their marriage is better after WLS, she admitted to not feeling fully supported by her partner immediately after WLS. Her partner was adamantly opposed to the surgery; perhaps this opposition was behind his sarcasm and refusal to support the participant. Another partner exhibited hostile dyadic coping when he minimized the seriousness of the WLS individual's stress; he stated he had heard her complaints so many times, he knew what she was going to say before she said it. The amount of negative dyadic coping expressed by the dyads was minimal; these two examples were the only instances of negative dyadic coping mentioned in the interviews.

Bodenmann's Theory of Dyadic Coping (2005) proved to be helpful in influencing the data collection and analysis of the dyad after WLS. Positive dyadic coping is associated with increased well-being, increased romantic satisfaction, and decreased stress levels (Bodenmann, 1995, 1997, 2005; Bodenmann, et al., 2006). Positive dyadic coping strengthens the feeling of "we-ness," mutual intimacy and trust, and the knowledge that the relationship is helpful and supportive (Bodenmann, et al.,

2006). Dyadic coping is viewed as a resource to help individuals cope with stressors, along with their other stress management and coping techniques. These dyads exhibited positive dyadic coping in dealing with the lifestyle changes after WLS. The dyads returned to prestressor functioning and maintained their homeostasis, coming together as one unit to deal with the stress of WLS.

Implications for Nursing Practice

Nurses caring for WLS clients must understand how WLS is experienced by the dyad. Surgeons routinely meet with the WLS individual's support person preoperatively to stress the importance of support for long-term success, indicating the support person is a vital piece in the individual's success. Knowing what the dyad can experience can help nurses tailor educational interventions to the dyad, giving them both preoperative and postoperative support to ensure both partners receive what they need. Educating the dyad on expectations and possible complications and giving them examples of positive dyadic coping can help the dyad respond appropriately to the stress of WLS. This in turn can help the WLS individual adhere to the regimen, ensuring long-term weight loss success. Maintenance of the dyadic relationship, with either positive growth or return to prestressor functioning is another positive outcome that may be influenced by adequate nursing intervention with WLS dyads.

Despite increasing awareness of fat bias, stigma and discrimination directed towards obese persons is prevalent. Some of these study participants continued to feel watched or stigmatized after their WLS. Healthcare professionals, including nurses, are guilty of this stigmatization and discrimination (Culbertson & Smolen, 1999; Davis-

Coelho, et al., 2000; Wolf, 2010; Zuzelo & Seminara, 2006). Even those professionals dedicated to obesity treatment can display these negative biases (Schwartz, et al., 2003). Gujral, Tea, and Sheridan (2011) concluded that even after bariatric sensitivity training, registered nurses' attitudes towards obese persons may improve, but beliefs about obese persons do not improve. Many inpatient facilities, especially those performing bariatric surgery, now offer bariatric sensitivity training for its healthcare professionals. Nurses at the bedside need to become aware of their own personal biases towards obese individuals, take advantage of bariatric sensitivity training offered in their region, and make a concerted effort to treat obese individuals with respect and dignity.

The United States has declared obesity a problem of epidemic proportion, yet there remains no consistent, aggressive, interdisciplinary approach to reduce the weight of the nation (Rowen, January 31, 2009). Nurses need to take action and become role models for their families, patients, and communities. Nurses are especially equipped to deal with the obesity epidemic through primary, secondary, and tertiary prevention, and through a variety of settings, including public health, inpatient facilities, schools, bariatric clinics, and primary care practices (Lowery, 2009). Nursing leadership in clinical settings, administrative settings, and policy settings can positively impact national policy on obesity and bariatric surgery (Lowery, 2009). Nurses have an immediate and pressing opportunity to change obesity policy and bariatric care at the bedside.

Implications for Nursing Research

WLS is a relatively new phenomenon in the world of nursing, and many nurses may not have provided direct care to anyone who had WLS. This procedure is becoming

more commonplace, and nurses must be aware of routine care and expectations preoperatively and postoperatively. While physical and psychosocial outcomes are beginning to be adequately researched from the perspective of other disciplines, nursing must become more invested in conducting studies on this population.

Studies similar to this one, but including more racially diverse dyads, dyads consisting of other relationships besides legal marriages, such as same-sex partnerships and cohabiting partnerships, a variety of socioeconomic classes, and in a variety of settings, should be conducted in order for the findings to be more generalizable to the general population.

Nurses provide much of the preoperative and postoperative education for WLS individuals. Nursing research needs to focus on what types of preoperative nursing education programs provide better outcomes postoperatively. What type of support programs result in increased adherence to the regimen? How often should the WLS dyad be seen postoperatively to maximize adherence? How can the dyad be best supported postoperatively to maximize coping with the stress of WLS? These are just some of the questions raised by this study that nursing research can answer.

Future studies need to investigate WLS individuals who have experienced dissolved intimate relationships after WLS to determine if dyadic coping was utilized. What, if any, effect did weight loss have on the demise of these relationships? What differences exist between this sample and a sample of those who had experienced a broken relationship? Are there any predictors of relationship demise after WLS? These

and other questions may be answered by investigating the experience of WLS for those people who have terminated relationships after WLS.

Many of the individuals who choose WLS as a weight-reduction tool may have obese partners who may also choose to undergo WLS. What is the intimate relationship like when both intimate partners have WLS? This phenomenon has not been investigated.

While WLS is a method of weight loss that can ensure long-term results, it is not the only method. Some individuals are able to lose a large amount of weight and maintain that weight loss with strict dietary control and exercise. For those individuals who lose a massive amount of weight without surgery, is their experience the same as those who chose WLS? Are their intimate relationships affected in the same way as those who chose WLS?

This study investigated intimate relationships one to seven years after WLS. More longitudinal studies investigating intimate relationships longer than seven years after WLS need to be conducted. Do intimate relationships change if weight is regained after WLS? These questions need to be answered in order to provide couples with as much information as possible prior to WLS.

Bodenmann's Theory of Dyadic Coping (2005) proved useful in influencing this study of the dyad after WLS. Other qualitative studies need to be performed using this theory in the context of other health issues that affect the dyad, such as chronic illness or traumatic events. This theory may prove useful in developing interventions aimed at

enhancing coping mechanisms and stress management techniques when dealing with health issues.

Investigating more phenomena using a dyadic perspective and the dyadic analysis method outlined by Eisikovits and Koren (2010) can provide a deeper understanding of how health issues are experienced by the dyad, instead of only having an individual perspective. Perception is reality in qualitative studies. The ability to use the perceptions and stories of both partners of the dyad enables nursing to combine and integrate both viewpoints, adding another dimension of reality for the couple under investigation (Eisikovits & Koren, 2010). Joint meaning is the essence of couplehood, and health concerns may affect this joint meaning. Conducting more studies using this dyadic analysis technique is the best way to capture the true meaning of the experience for the dyad.

Study Limitations and Assumptions

The limitations of this study are those inherent in the use of a qualitative research approach. This study is limited to the conditions under which the study was carried out, specifically the sample. A snowball sampling technique was used to recruit all ten dyads, limiting generalizability of the findings. The findings of this study were specific to the experiences of ten WLS dyads living in North Carolina. The sample consisted of seven women who underwent WLS and three men. Nine of the ten dyads were Caucasian. All of the dyads were legally married and had resided together for a minimum of ten years. The WLS individuals were in good health and experienced no serious complications or side effects after WLS. The sample is obviously limited and needs to be expanded to

include more racially diverse dyads, dyads consisting of other relationships besides legal marriages, such as same-sex partnerships and cohabiting partnerships, a variety of socioeconomic classes, and a variety of settings. Including participants who had experienced complications after WLS in a study may result in different findings related to dyadic coping.

The participants' stories were overwhelmingly positive in describing their experience and relationship after WLS. While it is possible that their experiences were mostly positive, there are factors that may have influenced these positive findings. First, the researcher's enthusiasm during the interviews may have unduly influenced the participants' responses. Social desirability bias, or the tendency for people to present themselves in the most positive light, could have distorted the true experience of participants (Fisher, 1993). Secondly, WLS requires a physical, emotional, financial, and a time commitment from the participants; these combined commitments may be seen as costly from various perspectives. The participants in this study may be rationalizing their decision to have WLS as a good one or describes their experiences as positive in order to justify these "costs."

Several of the participants discussed how the preoperative psychiatric evaluation did not fully prepare them for the changes after surgery and how more psychiatric treatment was needed before and after surgery to "fix" the mind, or the emotional reasons for overeating. Clearly these participants would be in favor of more intense preoperative and postoperative therapy to deal with the emotional causes of their obesity. This brief

preoperative psychiatric evaluation can be seen as a limitation to this study, as the participants were not fully prepared psychologically for the postoperative changes.

This study had four assumptions. The first assumption was that all members of the dyad would be willing to talk about their experience in the first year after WLS. Most participants were open and expressive about their experience; some of the male partners were reluctant to discuss anything of a personal nature. This may be due to discomfort felt when discussing personal and private issues with a stranger, a female investigator. Regardless of some participants' reluctance, enough data was collected to answer the research question. Second, WLS and the resultant lifestyle changes are stressors for the dyad. The WLS individuals did discuss feeling stress after WLS. Third, both members of the dyad must cope with the stress caused by WLS. Using Bodenmann's (2005) Theory of Dyadic Coping, the results of this study showed that the dyads utilized positive dyadic coping to deal with the stress caused by WLS. Finally, the stress after WLS may produce changes in the romantic relationship was an assumption. Stress did produce some changes in the dyadic relationship for some participants, but these changes were mostly positive. Some dyads learned how to cope with reasons for emotional eating and became more open with each other, strengthening the relationship.

Conclusion

This qualitative descriptive study provided a beginning description of the experience of the intimate dyad after WLS. Four themes were generated from analysis of the individual transcripts and dyadic analysis: (1) *No longer a slave to food*; (2) *Good and bad* with subthemes of *It's the best thing I've ever done* and *Just let me be normal*;

(3) *Surgery is a just a tool, not the solution*; and (4) *Support and accommodation*. The findings are consistent with past research and with Bodenmann's Theory of Dyadic Coping (2005). Implications for nursing practice and nursing research along with recommendations for future research were discussed. The experience of the dyad after WLS is a complex phenomenon that has a beginning description provided by this study.

Several of the findings in this study were similar to past research. This study found that marriages were either unchanged or strengthened after WLS, with no change or an increase in sexual functioning. Participants had both positive and negative experiences after WLS, but the positive aspects outweighed the negative ones. The dyad after WLS experiences a change in their relationship with food, trading in emotional eating habits for increased physical activity. WLS is a tool to be used for long-term weight loss; it is not a "quick fix". The dyad must be dedicated to adhering to the new lifestyle in order to maintain weight loss.

This study was unique in that it described the experience from both members of the dyad. No other studies could be found that interviewed partners of WLS individuals for their experience. This study also produced unique findings of the types of support needed by and given by both members of the dyad in the year following WLS. From seemingly minor events, such as cooking two different meals or ensuring the proper protein supplements were readily available, to major events like coping with repressed childhood abuse, support and accommodation by both dyadic members was essential. The descriptions of the types of support engaged by the dyad represented positive dyadic coping with this WLS stressor.

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APPENDIX A
INTERVIEW GUIDE

What is your relationship like for you after having weight loss surgery (WLS)? OR
What is your relationship like for you after your partner had WLS?

Has your relationship changed positively after WLS? In what ways?

Has your relationship changed negatively after WLS? In what ways?

How have you overcome these issues?

Are there any issues regarding your relationship that you are still working on?

Does your partner know about these issues?

Has your sexual relationship changed after WLS?

Positively?

Negatively?

In what ways?

Do you have any sexual issues that you are still working on?

Does your partner know about these sexual issues?

APPENDIX B
DEMOGRAPHIC FORM

What is your age? _____

How long have you and your partner been together in an intimate relationship?

How long have you and your partner lived together? _____

When did you have gastric bypass surgery? (n/a if you are the partner of the surgery individual)

Open incision: Yes No

Laparoscopic: Yes No

Have you have any major complications requiring hospitalization as a result of the gastric bypass surgery? Yes No

If so, what type of complication(s)? _____

When did the complication occur? _____

How long were you hospitalized due to this complication? _____

What is the highest level of education you completed?

Less than high school _____

High school graduate _____

Some college _____

College graduate _____

Graduate school _____

How do you identify your race?

White/Caucasian _____

African American _____

Asian _____

Hispanic _____

Native American/Alaska Native _____

Mixed racial heritage _____

I do not wish to answer. _____

APPENDIX C
CONSENT FORM

UNIVERSITY OF NORTH CAROLINA AT GREENSBORO

CONSENT TO ACT AS A HUMAN PARTICIPANT: LONG FORMProject Title: The Lived Experience of the Romantic Dyad after Weight Loss SurgeryProject Director: Kristen Barbee and Dr. Susan A. Letvak, PhD, RN

Participant's Name: _____

What is the study about?

This is a research project. This study is being conducted to find out what it's like for people and their romantic partners after weight loss surgery.

Why are you asking me?

I'm asking you to be a part of this study because either you or your partner had gastric bypass surgery at least one year ago but no longer than seven years ago. You also live with this person and have been in a romantic relationship with this person since before the surgery. You and your partner are at least 18 years old. You and your partner speak and understand spoken English, and you're both willing to participate and have your interviews held separately and be audiorecorded.

What will you ask me to do if I agree to be in the study?

If you and your partner agree to be in this study, you will be asked to take part in an interview with Ms. Kristen Barbee. You may choose the place where we meet for the interview. This place needs to be quiet and private. The interview will last approximately one hour. Your partner will also be interviewed, but at a separate time from you. Once all the interviews are completed and the interviews analyzed, Ms. Barbee will call you to see if you agree with her preliminary findings, or if the findings fit with what you said. This phone call should last approximately 30 minutes.

You and your partner will also be invited to participate in a second interview, together this time, to see if you agree with the findings of what the surgical experience is like for the couple as a whole. If you agree to participate in this second interview, you can expect to spend approximately another hour.

If your surgical experience was negative, you may feel stressed or upset during the interview. You may pause or stop the interview at any time if you become upset. Ms. Kristen Barbee will be happy to answer any questions you may have about this study; her cell phone number is 704-701-9197.

Is there any audio/video recording?

Yes, the interview will be audiorecorded with 2 recorders. This is so your words can be typed exactly as you said them. Because your voice will be potentially identifiable by anyone who hears the tape, your confidentiality for things you say on the tape cannot be guaranteed, although Ms. Barbee will limit access to the tape. The tape will only be heard by Ms. Barbee, Dr. Letvak (Ms. Barbee's advisor), and the person who types the interviews (if Ms. Barbee doesn't type them). All three persons who may hear the tape have signed confidentiality agreements and will not discuss anything heard on the tape with anyone who's not a part of this study.

What are the dangers to me?

The Institutional Review Board at the University of North Carolina at Greensboro has determined that participation in this study poses minimal risk to participants. You may become upset, angry, or anxious during the interview if your experience was negative. If you do become upset or emotional, you may pause or stop the interview. Ms. Barbee will provide you with numbers for your weight loss surgeon or local help lines if you become extremely upset.

UNCG IRB
Approved Consent FormValid 6/22/11 to 6/20/12

There may be a chance that someone involved directly with the study (Ms. Barbee, Dr. Letvak, transcriptionist) may recognize you based on your story. All of the above mentioned people will sign confidentiality agreements and will not reveal any information about you learned during playback of the interviews. The interviews will be typed, but you and your partner will be given false names during the typing process. Once the typed interview has been verified that it is word-for-word what you said, then the original interview recording will be deleted. All that will remain is the typed interview that will use false names. The typed interviews will be kept in a locked file drawer in Ms. Barbee's home office; Ms. Barbee possesses the only key to this file drawer. The audiorecordings will be stored on Ms. Barbee's laptop computer, which is password-protected, and will be deleted as soon as the typed interview is complete and accurate.

If you have any concerns about your rights, how you are being treated or if you have questions, want more information or have suggestions, please contact Eric Allen in the Office of Research Compliance at UNCG at (336) 256-1482. Questions, concerns or complaints about this project or benefits or risks associated with being in this study can be answered by Dr. Susan Letvak, who may be contacted at (336) 256-1024 or Susan_Letvak@uncg.edu

Are there any benefits to me for taking part in this research study?

There are no direct benefits to participants in this study.

Are there any benefits to society as a result of me taking part in this research?

Society may benefit as a result of you taking part in this research. Finding out what it's like for both you and your partner after weight loss surgery may lead to educational program development that may help future weight loss surgery individuals and their romantic partners cope better with the changes after surgery. These educational programs may help these people achieve their maximum weight loss and keep it off better.

Will I get paid for being in the study? Will it cost me anything?

You will receive a \$25 Wal-Mart gift card for participating in this study at the end of the interview. If you become upset and choose to stop the interview, you will still receive the gift card. It will not cost you anything to participate in this study.

How will you keep my information confidential?

All information obtained in this study is strictly confidential unless disclosure is required by law. The recordings will be deleted from Ms. Barbee's laptop computer (which is password protected) once the transcripts are completed and accurate. The typed transcripts, which contain no identifying information, will be kept in a locked file drawer in Ms. Barbee's home office. Ms. Barbee holds the only key to these file drawers. When typing the interviews, false names will be used instead of your real names. If the interviews reveal any instance of domestic abuse, Ms. Barbee is under legal duty to report this abuse to the police, which overrides any confidentiality promises. The original audiotaped recordings will be deleted/destroyed immediately after the interviews are typed into written text and verified for accuracy.

What if I want to leave the study?

You have the right to refuse to participate or to withdraw at any time, without penalty. If you do withdraw, it will not affect you or your medical care in any way. If you choose to withdraw, you may request that any of your data which has been collected be destroyed unless it is in a de-identifiable state.

What about new information/changes in the study?

If significant new information relating to the study becomes available which may relate to your willingness to continue to participate, this information will be provided to you.

Voluntary Consent by Participant:

By signing this consent form you are agreeing that you read, or it has been read to you, and you fully understand

UNCG IRB
Approved Consent Form

Valid 6/22/11 to 6/20/12

the contents of this document and are openly willing consent to take part in this study. All of your questions concerning this study have been answered. By signing this form, you are agreeing that you are 18 years of age or older and are agreeing to participate in this study described to you by Kristen Barbee.

Signature: _____ Date: _____

UNCG IRB
Approved Consent Form

Valid 6/22/11 to 6/20/12

APPENDIX D

MEANING UNITS AND PARTICIPANT STATEMENT EXAMPLES

Reason for surgery

1. My health was getting really bad. I was starting to lose kidney function. I was a really bad diabetic, on all types of medication.
2. But I wanted to be healthy, because, you know, I – I couldn't walk around the mall. I couldn't do any of those sorts of things, and he'd get aggravated because when we'd go on vacation, go to the beach and that sort of thing, um, I didn't feel like getting out and walking and going anywhere.
3. Just, you know, uncomfortable physically, uncomfortable emotionally, and just – it just was steadily getting worse and worse.

Adherence

1. She has stuck with it. She has done a great job, not a perfect job, nobody's perfect, but she's done a really good job of being adherent to the diet of trying to do things such as avoid drinking with meals, try to avoid the supersweet stuff.
2. We both be sitting here and there's another couple that want it, and we'll tell 'em how good everything has been and how easy it is, but, afterwards, there's some life-changing experience. You have to stick with it. You have to watch what you eat. You have to work out, you know, but – or else the weight can come back. It's not just a little lap band thing, you know. You have to be ready for it and commit to it. And so we tell 'em, you know, we tell 'em

straight out, you have to exercise, you know, it's a life changing experience.

But I would – I would recommend it for anybody.

Accommodating partner

1. I've tried to encourage him, and, you know, he got on the scales, I think he – when he went to the doctor two weeks ago, he said, "Oh, I need to start cutting back." I said, "Well, this is where you're going wrong, you're getting back into that same eating at night, eating something salty, then eating something sweet. You're satisfying all your cravings, but you're overeating."
2. OK, I'll give you a good example. He likes everything fried. OK, when we went on vacation last year, I was three weeks out of my surgery and just starting to eat like chicken, fish and stuff like that. Well, he's not, he doesn't really like baked chicken and stuff all that well, but when we went to this certain restaurant, he ordered baked chicken and we shared a plate because I couldn't eat but a small amount--and it was so expensive there. That really touched me because normally he would've ate the fried chicken, but he compromised and. Very supportive.

Life too busy

1. Not really, once in a while. I guess now we are all eating better. We seem to sit down more as a family and eat more instead of I guess our schedule is more hectic because of baseball 4 or 5 nights a week or football or basketball, whatever. It's hard to get everybody together at once.

2. That is completely unrelated to the surgery, and she is now a graduate student studying online so that is taking a lot of her time, so that has robbed her libido somewhat but that has, again, nothing to do with the surgery. I would say, yeah, we're kind of going through a tough patch right now and she has other external stressors but at least we don't have her weight hanging over her as an additional stress right now.

Sex is better

1. I think positively, because neither one of us feels like we're going to die. We don't talk about it and roll over and call that oral sex (laughs). It used to be, I didn't feel good about myself. It got to the point that the heavier I got, I didn't feel good about myself, and then, of course, after the gastric bypass, we had to deal with the intimacy issue with me just finally dealing with the abuse. We got through that hell of a year in that regard, but intimacy is good. When we have time, we lock the door when everybody's asleep. It's a lot better. I'm present.
2. I mean, just the process of getting rid of some of that pannus, you know, you can actually do something. (Laughs) Because that really gets in the way.
(Laughs)

Sex is worse

2. Um, he kind of thought that I would be more interested in sex, but that ain't the case either (laughs). In fact – in fact, my – I want it less now than I did. But when I started losing so much weight and getting so much smaller, it was

painful. I don't know if it's because there's nothing down there anymore but bone. Before, you know, it – I guess I had enough padding down there. But, you know, you just – it – it just – it – it hurts sometimes. Seriously, you've got all this hanging skin, and even in your vagina area - is a lot of hanging skin, and there's no – there's no fat down there anymore, and it does hurt, I'll be honest with you. It's painful.

Sex unchanged

1. I really don't think there's been much change –positive or – or negative. It's been about the... about – about the same.
2. Our sexual relationship has always been good. With the weight or without the weight. So, it – it never – that part never really changed for us.

Marriage changed

1. Our marriage now is good. It's strong. I think it's probably stronger for us than it was initially, because we had to go through a lot of emotional change. I went through a lot of emotional changes. I mean, I was overweight because I was a food addict. That's just what it was, so when I couldn't have that drug of choice available to me anymore, even when I wanted it, I went through a lot of depression like the first I guess 6 months to a year off and on, and so that kind of strained us a little bit, but we learned how to talk about that. So, I think our marriage now is stronger than it was before.
2. But, um, it's like I think we're better than we've ever been, right now. And I'm sure that surgery had something to do with it, to make it even better.

Marriage unchanged

3. Um, it really hasn't really changed a whole – you know, a whole lot. Um, we've always been, you know, very close, um, very honest with each other. Um, I – I think we have just a really good relationship, a very close relationship. I mean, we're – we're both Christians, so it's a Christian-based relationship.
4. I don't think there's a lot of difference in our marriage since surgery. I've always had a very busy life. She's always had a very busy life, (laughs) so, you know it's been much the same, I'd say. We have two children, so they keep us very busy between my work, her work, my school, and we are active in our church, so there is always something to do.

Surgery is a tool

3. ...the emotional eating, the eating at night, that has resurfaced, so in that part I'm kind of disappointed that – that didn't completely – it can't cure the mind, it's still going to be there.
4. Ultimately, the weight loss surgery is just a tool, it's not the solution. It's just a tool. She still had to find that motivation from within to realize, I've got a problem with eating, and I've got to stop.

External interference

1. But he does – he does say, "You eat more now than you did before the surgery." I say, "What do you mean?" He'd say, "Well, every time I look at you, you're eating." I said, "Bill, it's not that I'm eating more; I'm eating

more often. Before, I could sit down and eat two cheeseburgers. Now, it takes me all day long – I mean, I can only eat like three, four ounces of food at a time, so in two hours I’m eating (laughs) something else,” I said. So that kind of stuff.

2. His mom lives with us. I wasn’t even thinking about this as far as our marriage. She, as far as in our marriage, he has a hard time feeling trapped between us sometimes, because, early on, she deliberately tried to sabotage my success. She’s very odd like that. She’s older, she’s 80. His dad has passed away. She’s very manipulative and passive-aggressive, it’s just her personality. That caused a little bit of a strain. It got back to me that, and I think part of his jealousy issue might have stemmed from that, I don’t know, but that she was telling people in her family that she thought since I lost my weight I might go looking elsewhere. So, that was a negative thing.

Other’s perceptions

1. Exactly. And – what was it? Somebody’s birthday two weeks ago at church, and they had – they had it at choir practice one night. Well, somebody had brought a cake in, and I took maybe – maybe two – two teaspoons of the cake over on my plate, you know. And I just kind of ate it slow and stuff. Well, one of the persons in the choir made a comment to me, “Well, if you keep on eating stuff like that, you’re gonna gain all that weight back.” You know, it wasn’t somebody’s business, you know? That’s just the way I feel about it. And, at first, I would tell people I had surgery, and now I don’t. When I see

people that hasn't seen me and don't know, they'll say, "Barbara, you look so good! How'd you lose all that weight?" I say, "Oh, I just watch what I eat." I quit telling them because I think people watch you after you've had that surgery. They watch every bite you put in your mouth. And I don't know, it just kind of makes me self-conscious about it. And I've noticed my mom kind of does that, and my dad kind of does that. They'll watch to see how much food I have on my plate, you know. Mama said, "Oh, you're eating a little bit more now than you used to," and I said, "Well, I may eat all that, I may not," you know.

2. It's – it's not. It just feels like I'm being watched, you know? And when we do have eating situations or like, you know, going to a Baptist church, you eat all the time.(laughs). I mean, seriously, every event you have is – is – is surrounded by food. And, uh, you know, I mean, sometimes I go, and I'll just maybe not eat anything just so people won't see what I'm eating. I mean, I'll just wait till I get home and eat.

Secrecy

1. And, at first, I would tell people I had surgery, and now I don't. When I see people that hasn't seen me and don't know, they'll say, "Barbara, you look so good! How'd you lose all that weight?" I say, "Oh, I just watch what I eat." I quit telling them because I think people watch you after you've had that surgery. They watch every bite you put in your mouth.

2. And, even when I went to see [Dr. X] to have the surgery, I didn't take him, I took my best friend, because I'm not sure he even knows what I weighed. I never told him. I was just too embarrassed. I don't know if he even knows how much I weighed because I always kept that from him. I would never tell him that. I mean, cause, when we got married, I weighed like 125 pounds and I had gained up. My heaviest weight was 254.

Regret

1. I cried for the first two months after I had this surgery. Yeah. I did. I cried, and I was like, What have I done? This is the worst thing I've ever done.
(Laughs) Um, I – I don't know if it was because I was – I don't know. I – I – I don't know, because, you know, I'd go in there and cook and couldn't eat it. And nobody would ever say, "Thank you, Mom," or, "Thank you, honey, for fixing – I know you can't eat it, but –" you know. And I'd get depressed and – because I'd have to go back in there and clean up dishes and things that I didn't even get to eat and – you know. I don't know, I just – I was just – just kind of depressed for the first two months. I don't know if everybody's been through that, but the first two weeks when you can't eat anything but drink that little one-ounce thing every hour. And then my husband would say, "What's for supper?" and I was like (audible sigh), "I don't know. I have no idea what I'm gonna fix for supper. Here! Drink some of this if you want to know what's for supper!"

2. You know, and that, I have a little bit of remorse for that because we just don't do that anymore. Going to a restaurant here is not a celebratory thing anymore.

Negative body image

1. I would say my wife's self image is probably always going to be a sore spot with her. It's something she's very sensitive about and her physical appearance. You know, she'll try on 3 or 4 outfits before we go somewhere. It's like, does this look okay? I'll say, honey, you look great, but it's like she doesn't believe me, and I don't know if every wife does that or if that's a function of her personal history of where she's been or where she is now, that she's just not trusting her eyes when she looks in the mirror. I don't know what she sees through her eyes when she looks in the mirror because of the history that she brings, but I know she looks fantastic.
2. She's done a lot of public speaking and has even gone to Canada in her educational pursuits. No one would know that, but – but inwardly, she still feels very, very big.
3. Now, I look a lot different to myself in a lot of ways. But there's still the part of me that is three hundred pounds.

Fear

1. He really didn't know my concerns going into surgery, as far as being scared of every day seeing him the size that he was, because I just didn't – I didn't want to frighten him, either.

2. And the things I remember about gastric bypass surgery, some of them were the worst stories, horror stories, actually. And I actually knew some people that had not done well with it at all. So, yeah, I was – I was reluctant, just scared of infection and, you know, any mishaps with the re-anastomosis, and, I mean, a lot of things scared me about it.
3. And I backed out one time of the – starting the process ‘cause I got freaked out about it.

Complications

1. This has got to do with losing lots of weight is incontinence. I cough and – and sneeze and laugh, and I wet myself. And I’m going to tell you, and I know this is personal –But all the hanging skin, even down there, it’s a lot of hanging skin. And I saw someone on TV that had mentioned that, and I thought, Hm, you know, like that, but it’s the truth. Seriously, you’ve got all this hanging skin, and even in your vagina area –is a lot of hanging skin, and there’s no – there’s no fat down there anymore, and it does hurt, I’ll be honest with you. It’s painful.
2. I had a kidney stone on top of the nitrous in my belly and all that good stuff and apparently tried extubate myself and climb out of the bed, and they were trying to manage my pain. Got me extubated, everything seemed stable, and then it went wild again and they gave me more pain medicine, and then I arrested.

Positive experience

1. It is. I mean, you know in church, he'll hold my hand now, where, you know. I don't know, and it could've just been me, but for a couple years there, you know, it wasn't like that, and it's like that again. It's awesome. It's awesome. The best thing I've ever done in my life, I think.
2. It's awesome. I see that joy on her face when she's able to do those things. That's priceless. In fact, my kids have on various occasions made comments about, wow mom, you're doing this now or, you never would've done that before. They are very proud of her. She set a great example for them that, you know, sometimes things are so important you have to make a stand, you have to make a decision and follow through with it. Absolutely 100% certain, no questions asked. It's been one of the best things for her that she possibly could've done.

More confident

1. My wife's self-esteem is higher. I know it is. She's always been outspoken but now she's more outspoken. It doesn't bother her to tell me what she thinks.
2. I am more confident. I enjoy going out more now than what I used to. I enjoy clothes now more than what I used to. Now, I don't mind if I'm working out in the yard to take my shirt off. Before, I was, you know, kind of self-conscious about things. I never felt that way so much in my family but in public more so. You know, I'm more confident in myself and you know,

just... Your appearance means a lot to you and it affects you, so I just feel better.

More active

1. Oh, my gosh. I have more energy. I mean, it used to be my kids were younger and, thank God, I did this when I they were younger and didn't waste so many years. I had no energy. There were things I wouldn't do, things they wanted to do, like paddleboat. I just bought a kayak, something I promised myself that when I lost my weight I was going to learn to kayak, flat water, not white water. That kind of stuff that they wanted to do that I would never do because #1 I was embarrassed because I physically couldn't do it and I didn't want the embarrassment and #2 I just felt like crap. I'd rather lay on the couch and eat a Twinkie than get up and play with them. So, going out and doing stuff in the yard, you know, we don't do it every single day, but that's changed. They recognize that I feel better and that I'm a different mama than I was before even as young as they are. I think that's helped a lot.
2. Now, on the weekends, I just go and come. I keep a pedometer on me. I try to do about at least ten thousand steps a day. On weekends, when I'm working at [employment place] – I think last night when I took it off I had eighteen thousand – and I didn't even walk or exercise. Um, I try to run about eight thousand, but I got runner's knee, Patellofemoral Syndrome, a little bit, but I'm not really worried about it. They told me just to back off, so I started swimming because I want to do, uh, a real triathlon. I've done a kayathlon,

and I didn't do ... And I bike, and I run. Um, I've hit my – I don't know you would say hit my peak 'cause I've – I've got my first place, second, and thirds in my age group.

Increased opportunities

1. I really don't think that probably I would've ever changed jobs had I not lost the weight that I had lost. I don't know that I would've felt confident enough in myself to go and take on working with primarily 20-25-30-year-old ranges, learning a whole different career and getting back into a lot more physical labor in the clinical setting than what I was in in administrative roles. In that respect, it's changed a lot in opportunities for me that have opened up that I don't think probably would have had I not done that.
2. But, you know, coming to (University A), moving towards tenure, gaining tenure, getting some funding, having lots of support, being in a good position there, um, getting tenure, moving on to this job that I'm in now, you know, all that stuff has been more possible.

Improved health

1. My health was really getting bad. I was starting to lose kidney function. I was a really bad diabetic, on all types of medication. I am on zero, nothing. My vitamin, my calcium and my thyroid medicine is the only thing I take. Even though I don't have to take my sugar, I still do it once a week. 81 was what it was this morning, and it was like 280, 300 every day. It's awesome. Awesome.

2. And I see us being together many years longer because of it, so...he's much healthier. He's off all of his medicines. 'Cause he was getting on up to some serious blood pressure and, um, triglycerides and cholesterol, and his family history is very strong for heart disease. His dad died with heart disease, all of his uncles, his mom.

Improved body image

1. As a matter of fact, she went and got her driver's license back almost a year ago. They didn't believe it was her, so she had to show all this proof. The other week, she goes to the dentist. The dentist looks at her, you know, and they weren't sure it was her, too. They got her picture out and she had to show some ID, and they said well where's the other part of you? (both laughing) So, it makes her feel good when people see that, you know, and people comment on her weight loss, you know, it's good.
2. Even at my heaviest, he always told me every single day that he loved me and I was beautiful. As we get older, everything is going to wrinkle and fall. That's important to me. Now I believe him. He's told me that all along but I didn't believe him, because I didn't believe in myself.

Sharing with others

1. I have actually been a proponent for several others that have gone and gotten it since I have. We have had a good support network there just in friends and social contacts I'm aware of that have had that.

2. I would tell him – and I have talked to several other, um, couples, and letting ‘em know, you know, what I went through and my good experience and how great things have been. And my husband did the same.

Concern with others' feelings

1. Don't be guilty that you can drink it and I can't. Don't be guilty that you can go drink a half bottle of wine and I'm not going to.
2. ...other than if I did eat something I shouldn't have and I'd throw up, and I hated that because I didn't want anybody to think I was throwing up because it was what they cooked. It's my body, not them. I don't think that it ever came across that way, though. It never was said, why do you throw up whenever I cook. It's never been an issue like that.

Couldn't do it on my own

1. That is the only thing that will get rid of diabetes, they said, is gastric bypass surgery, unless you can lose it on your own, which I could not. I, I guarantee you I tried every fad diet there was out there. I tried everything. I went to the doctor and got diet pills. I done everything. Nothing worked. Nothing. I went to Weight Watchers. I went to Formula 3. I done everything possible. Nothing worked. Nothing.
2. And so it wasn't that, but my health got to be a issue. And I tried all kind of diets, and nothing was working. And so I knew I had – it was time for me to do something. And I couldn't because I – I had all that extra weight. I just couldn't. I would start out trying to walk at least ten, fifteen minutes. And I

would probably do that, if I did it twice a week. And then I'd give up. I just couldn't do it 'cause it was too much weight to try to – I couldn't keep myself motivated. And then I couldn't keep up with other people that would exercise, only because I was so big. So I needed to lose some of the weight and then I – so I was trying think in my head, If I could lose some of the weight, then I probably could exercise, but I couldn't stay on a diet long enough to lose the weight.

Change in relationship with food

3. Yeah. Actually, initially, yes. And – and I think about we used to – before children, we used to go on cruises occasionally. And, you know, that is a big eating fest, and I've thought about it – since then, thought, Well, would we really enjoy something like that so much? Because neither one of us are very physically, um, active. We don't do sports. It's not like we would go on a cruise and decide to go scuba diving. Or, you know, rock climbing. We might do a little bit of it, but our fun was, you know, um, eating. Adam likes to play the slots. But, yeah, I guess because you don't enjoy it as much because you're afraid. Um, when we would go out to a buffet, he loved and still tried to eat some of the stuff at the buffet, but before we left he was in the bathroom throwing up. So it's hard to enjoy that sort of thing. We finally just gave up the buffets and said that was the end of that .
4. We ate. Growing up, I mean – and this is my family growing up, and then now it's like, you know, as soon as somebody has a birthday it's like, "Where

are we going to dinner?” “Where are we gonna go? Where are we gonna go to dinner?” And my birthday this year, what I really wanted to do, which we ended up not really being able to do much of anything, but what I wanted to do was to get a kayak for the day. That’s what I wanted to do. You know, I don’t want to focus it on the food. Um, we – I take my daughter to the beach. And we go to the pool. We go to the park, um, we walk the neighborhood.

Decision-making

1. My cousin actually had it. She’s a hairdresser and she had started cutting my hair. Me and my sister had been talking about it. I had thought about it and, you know, researched it for 2 years before I actually took the plunge to do it, because it’s a lot. You don’t just go do it.
2. Because he spent a year psyching himself out and getting ready for this surgery, you know. I knew the weight was bothering him because when I met him, he was like this (indicating thin). And life in general and his job and international traveling and all of that played into the weight gain. And just – sometimes, just international traveling was a strain on us within itself.

Needs Control

1. But I was just obsessed with everything being done right. Everything had to be right.
2. I mean, everything I – it just had to be done a certain way. I mean, the girls at work even noticed it, you know, and they would come in my classroom and

everything. I mean, I would be telling the kids, “Put that back on the shelf this way! That’s not how it goes!”

3. And it’s just simply that I don’t want to ever be out of control in public.

Life (Food) is different

1. Yeah. That’s probably the biggest thing, just what can he have. He always used to cook, but he was used to cooking for all his brothers and sisters and he would cook enough for 10 people and he can’t eat that much now. When he fixes spaghetti, he does a whole pot and it’s thrown out before we ever eat it because you can’t eat it like you used to, so that kind of thing. Not anything major, just the little things.
2. That’s been awesome because he cooks all the time. I love him. And he’s always trying these new recipes, or he just gets stuff and puts it together, and it’s just good. He’s the most wonderful cook and is conscientious with it. Yeah, I mean, and he’s always digging out recipes out of magazines or finding something online. Um, we’re having – he’s – he’s eaten something somewhere and finds out it was good, and he’ll come home and experiment. Yeah, I love that part.